

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

36 14501

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary K. Yuskovich

2. Date of Death

Month Day Year  
May 16, 1996

3. Time of Death

4:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Meridian Nursing Center Loch Raven

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

218-07-7473A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1/16/1895

9. Birthplace (State or Foreign Country)

Austria

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8757 Old Harford Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Kusmiak

18. Mother's Name (First, Middle, Maiden Surname)

Maria

19a. Informant's Name/Relationship (Type, Print)

Mrs. Julia Aymold

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8757 Old Harford Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Trinity R/O Cemetery 5/18/96 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Monten J. Dippel

22. Name and Address of Facility

The Dippel funeral Home Inc.  
7110 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure  
Due to (or as a consequence of):b. Dehydration  
Due to (or as a consequence of):c. Dementia  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sireesh K. Tripuraneni

29c. License number

D 30661

29d. Date signed (Month, Day, Year)

May 17<sup>th</sup> 1996.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sireesh Tripuraneni MD, 5670B The Alameda Baltimore, Maryland 21239

31. Date filed (Month, Day, Year)

MAY 17 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

96 14502

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ZICKWOLF</b>				2. Date of Death Month <b>May</b> Day <b>8</b> Year <b>1996</b>		3. Time of Death <b>8:15 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2502 FAIRWAY DR.</b>				4b. City, Town, or Location of Death <b>BELAIR</b>		4c. County of Death <b>HARFORD CO.</b>		
Funeral Director	5. Social Security Number <b>149-09-1142</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 29, 1913</b>		
	9. Birthplace (State or Foreign Country) <b>WOODBURY N.J.</b>		10a. State <b>N.J.</b>		10b. County <b>GLOUCESTER</b>		10c. City, Town or Location <b>WOODBURY</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>448 JACKSON ST.</b>		10f. Zip Code <b>08096</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>		16b. Kind of Business/Industry <b>JUDICIAL</b>		17. Father's Name (First, Middle, Last) <b>CHARLES E. WALRAVEN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FLORENCE D. BAILEY</b>	
19a. Informant's Name/Relationship (Type, Print) <b>ELAINE BIERMANN</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2502 FAIRWAY DR. BELAIR, MD. 21015</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EGLINGTON CEM.</b>		20c. Location - City or Town, State <b>CLARKSBORO, N.J.</b>	
21. Signature of Funeral Service Licensee <b>Thomas J. Skarda Jr.</b>		22. Name and Address of Facility <b>SKARDA F.H. 2829 HUDSON ST. BALTO, MD. 21224</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC BREAST CANCER</b>		Approximate Interval Between Onset and Death <b>6 MONTHS</b>			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John F. Edwards, MD</b>		29c. License number <b>D31775</b>		29d. Date signed (Month, Day, Year) <b>MAY 8, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John F. Edwards, MD</b>		31. Date filed (Month, Day, Year) <b>MAY 17 1996</b>		32. Registrar's Signature <b>John F. Edwards, MD</b>		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2712 BELAIR ROAD GAITHERSBURG, MARYLAND 20878</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

96 14503

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GORDON CLARK</b>				2. Date of Death Month <b>MAY</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>1255PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>LEVINDALE Geriatric Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-18-2435</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 25, 1922</b>	9. Birthplace (State or Foreign Country) <b>Hot Maryland</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>N/A</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>		10e. Street and Number <b>4116 Amis Avenue</b>	
	10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>1</b> <input checked="" type="checkbox"/> Navar Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No If Yes, Give Year or Dates: <b>2-4-43-46</b>				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>12 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Automobile Painter</b>		16b. Kind of Business/Industry <b>Automobile Body Shop</b>	
	17. Father's Name (First, Middle, Last) <b>Stutney Clark</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Viola Holcomb</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Maclene Edwards, Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4116 Amis Avenue Baltimore, Maryland 21215</b>			
	20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Barrison Forest Vet. Cem.</b>		20c. Location - City or Town, State <b>5-16-96 Owings Mills, Md</b>	
	21. Signature of Funeral Service Licensee <b>James Harris</b>				22. Name and Address of Facility <b>CHATHAM - Amis Funeral Home 5240 REISTERSTOWN ROAD Baltimore, Maryland 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>a. ANOXIC ENCEPHALOPATHY</b></p> <p><b>b. CHRONIC PANCREATITIS</b></p> <p><b>c.</b></p> <p><b>d.</b></p> </div> <div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>PROSTATE CANCER, HTN, DM</b>							
23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input checked="" type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)				
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
				28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Matthew McNabney</b>				29c. License number <b>D45757</b>		29d. Date signed (Month, Day, Year) <b>MAY 10, 1996</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>MATTHEW MCNABNEY 2974 W Belvedere BALTIMORE 21215</b>								
31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>				32. Registrar's Signature <b>John H. Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

4+1



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State of Maryland / Department of Health and Mental Hygiene

96 14504

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIVIAN JOSEPHINE COOPER</b>				2. Date of Death Month <b>MAY</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>5:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MERCY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>213-28-2685</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR 25 1928</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5510 NARCISSUS AVE</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1 YEAR</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC WORK</b>		16b. Kind of Business/Industry <b>DISPLACED HOMEMAKER</b>			
	17. Father's Name (First, Middle, Last) <b>MARCO M. GRANT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>TESSIE POWELL</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DEBORAH BRODIE, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8401 ALLENWOOD ROAD RANDALLSTOWN, MD 21133</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LORRAINE PARK CEMETERY</b>		20c. Date <b>5-18-96</b>		20d. Location - City or Town, State <b>WOODLAWN, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>CHATHAM - HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21245</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SEPTICEMIA</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>LUNG CANCER</b>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1. <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2. <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3. <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature] M.D.</b>		29c. License number <b>P09133</b>		29d. Date signed (Month, Day, Year) <b>MAY 12, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVID BADAWI, M.D. MERCY MEDICAL CENTER, BALTIMORE</b>								
31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14505

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PETER GUERDIO</b>				2. Date of Death Month <b>MAY</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>03:30</b>	
	4a. Facility Name (If not institution, give street and number) <b>UMMS</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-24-2873</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 3, 1929</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>4422 Annapolis Road</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1951-53</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Parts Manager</b>		16b. Kind of Business/Industry <b>Industrial Equipment</b>		
17. Father's Name (First, Middle, Last) <b>Stephen Guercio</b>				18. Mother's Name (First, Middle, Maiden Sumame) <b>Caroline Legambi Guercio</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Vera Guercio - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4422 Annapolis Road, Baltimore, Md 21227</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park</b>		20c. Location - City or Town, State <b>5-13-96 Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ambrose Funeral Home of Lansdowne 21227 2719 Hammonds Ferry Road, Baltimore, MD</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>INTRACEREBRAL HEMATOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>7301</b>		29d. Date signed (Month, Day, Year) <b>MAY 10, 1996</b>		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>DAVID HARTER 22 S. GREEN ST, BALTIMORE, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14506

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Phyllis Eugenia Hammond</b>				2. Date of Death Month <b>5</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>9:52 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greenspring Nursing and Rehab. Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-14-3448</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 2 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>601 WYANOKE AVENUE</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPER</b>		16b. Kind of Business/Industry <b>Private family</b>			
	17. Father's Name (First, Middle, Last) <b>Edward HERMAN Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Williams</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Doris BROWN, SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>318 LENNOX AVE Towson, Maryland 21286</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		20c. Location - City or Town, State <b>Parabutus, Md</b>		20d. Date <b>5-20-96</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Debra Harris</b>				22. Name and Address of Facility <b>CHATA AN - LARRY'S FUNERAL HOME 5540 ROSTERSTOWN ROAD BALTIMORE, MARYLAND 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>END STAGE LIVER FAILURE</b> Due to (or as a consequence of): b. <b>HEPATIC CIRRHOSIS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PROGRESSIVE HEPATIC ENCEPHALOPATHY</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Robert E. Roby, M.D.</b>		29c. License number <b>D-19425</b>		29d. Date signed (Month, Day, Year) <b>5/15/96</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROBERT E. ROBY JR, M.D. 827 LINDEN AVE BALTO, MD. 21201</b>				31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>			
	32. Registrar's Signature <b>John S. Barker-Randall</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14507

Item: 7 per F.H. G-744 2/11/97 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THELMA Mae HASKINS</b>				2. Date of Death Month Day Year <b>MAY 15, 1996</b>		3. Time of Death <b>3:05 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-44-5786</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 8, 1944</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>908 Valley Street #2</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>11th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse Assistant</b>		16b. Kind of Business/Industry <b>Nursing Home</b>		17. Father's Name (First, Middle, Last) <b>CHARLIE Haskins</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN Tull</b>		19a. Informant's Name/Relationship (Type, Print) <b>TANGELA Haskins, Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5413 Remmell Ave Baltimore, Md 21206</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		20c. Date <b>5-23-96</b>		20d. Location - City or Town, State <b>Baltimore, Md</b>		21. Signature of Funeral Service Licensee <b>Sunny Harris</b>	
	22. Name and Address of Facility <b>CHATHAM - HARRIS Funeral Home 5540 REISTERSTOWN ROAD BALTIMORE, Md 21215</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Heart Failure</b> Due to (or as a consequence of): b. <b>Myocardial Infarction</b> Due to (or as a consequence of): c. <b>Coronary Artery Disease</b> Due to (or as a consequence of): d. <b>Diabetes, Hypertension, Hypercholesterolemia</b>		Approximate Interval Between Onset and Death <b>2 weeks</b> <b>2 weeks</b> <b>7 years</b> <b>10 years</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760,	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <b>Rajat Bannerji MD</b>		29c. License number <b>N4312</b>		29d. Date signed (Month, Day, Year) <b>May fifteenth, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RAJAT BANNERJI The Johns Hopkins Hospital 600 North Wolfe St. Baltimore, Md</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>		32. Registrar's Signature <b>John Andrew Ricketts</b>		33. Date of Death (Month, Day, Year) <b>MAY 15 1996</b>		34. Time of Death <b>3:05 A.M.</b>	



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14508

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div style="font-size: 1.2em;">Lula Heiderman</div>				2. Date of Death Month Day Year <div style="font-size: 1.2em;">May 14 1996</div>		3. Time of Death <div style="font-size: 1.2em;">4:34 PM</div>				
	4a. Facility Name (If not institution, give street and number) <div style="font-size: 1.2em;">Harbor Hospital Center</div>				4b. City, Town, or Location of Death <div style="font-size: 1.2em;">Baltimore</div>		4c. County of Death <div style="font-size: 1.2em;">N/A</div>				
<b>Funeral Director</b>	5. Social Security Number <div style="font-size: 1.2em;">215-05-8283</div>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <div style="font-size: 1.2em;">86</div> Yrs.		8. Date of Birth (Month, Day, Year) <div style="font-size: 1.2em;">Jan. 1, 1910</div>				
	9. Birthplace (State or Foreign Country) <div style="font-size: 1.2em;">Maryland</div>										
Usual Residence of Decedent											
10a. State <div style="font-size: 1.2em;">Maryland</div>			10b. County <div style="font-size: 1.2em;">Baltimore</div>			10c. City, Town or Location <div style="font-size: 1.2em;">Baltimore</div>					
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number <div style="font-size: 1.2em;">2809 Oak Grove Avenue</div>				10f. Zip Code <div style="font-size: 1.2em;">21227</div>		10g. Citizen of What Country? <div style="font-size: 1.2em;">United States</div>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <div style="font-size: 1.2em;">white</div>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <div style="font-size: 1.2em;">7</div> College (14 or 5+) <div style="font-size: 1.2em;"></div>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <div style="font-size: 1.2em;">sales clerk</div>			16b. Kind of Business/Industry <div style="font-size: 1.2em;">department store</div>					
17. Father's Name (First, Middle, Last) <div style="font-size: 1.2em;">William F. Vankirk</div>				18. Mother's Name (First, Middle, Maiden Surname) <div style="font-size: 1.2em;">Alice N. Wipple</div>							
19a. Informant's Name/Relationship (Type, Print) <div style="font-size: 1.2em;">Alfred W. Ashenbach, son</div>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div style="font-size: 1.2em;">4462 Fenor Road Baltimore, Maryland 21227</div>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <div style="font-size: 1.2em;">New Cathedral Cemetery</div>		20c. Date <div style="font-size: 1.2em;">5/17</div>		20d. Location - City or Town, State <div style="font-size: 1.2em;">Baltimore, Maryland</div>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <div style="font-size: 1.2em;">Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227</div>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table style="width:100%; border: none;"> <tr> <td style="width: 30%; vertical-align: top;">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td style="width: 60%; border-left: 2px solid black; padding-left: 10px;">                 a. <div style="font-size: 1.5em;">Respiratory Failure</div>                  Due to (or as a consequence of):                  b. <div style="font-size: 1.5em;">Chronic Obstructive Pulmonary Disease</div>                  Due to (or as a consequence of):                  c.                   Due to (or as a consequence of):                  d.             </td> <td style="width: 10%; vertical-align: top; text-align: center;">                 Approximate Interval Between Onset and Death   <div style="font-size: 1.5em;">17 days</div>   <div style="font-size: 1.5em;">15 years</div> </td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <div style="font-size: 1.5em;">Respiratory Failure</div> Due to (or as a consequence of): b. <div style="font-size: 1.5em;">Chronic Obstructive Pulmonary Disease</div> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death  <div style="font-size: 1.5em;">17 days</div>  <div style="font-size: 1.5em;">15 years</div>
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <div style="font-size: 1.5em;">Respiratory Failure</div> Due to (or as a consequence of): b. <div style="font-size: 1.5em;">Chronic Obstructive Pulmonary Disease</div> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death  <div style="font-size: 1.5em;">17 days</div>  <div style="font-size: 1.5em;">15 years</div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <div style="font-size: 1.2em;">M</div>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <div style="font-size: 1.2em;">md - intern</div>				29c. License number <div style="font-size: 1.2em;">AS2441614-30</div>		29d. Date signed (Month, Day, Year) <div style="font-size: 1.2em;">May 14 1996</div>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <div style="font-size: 1.2em;">Lawrence Jack Fogelson</div>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <div style="font-size: 1.2em;">Harbor Hospital Center 3001 S. Hanover St. Baltimore, MD 21225</div>							
31. Date filed (Month, Day, Year) <div style="font-size: 1.2em;">MAY 18 1996</div>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

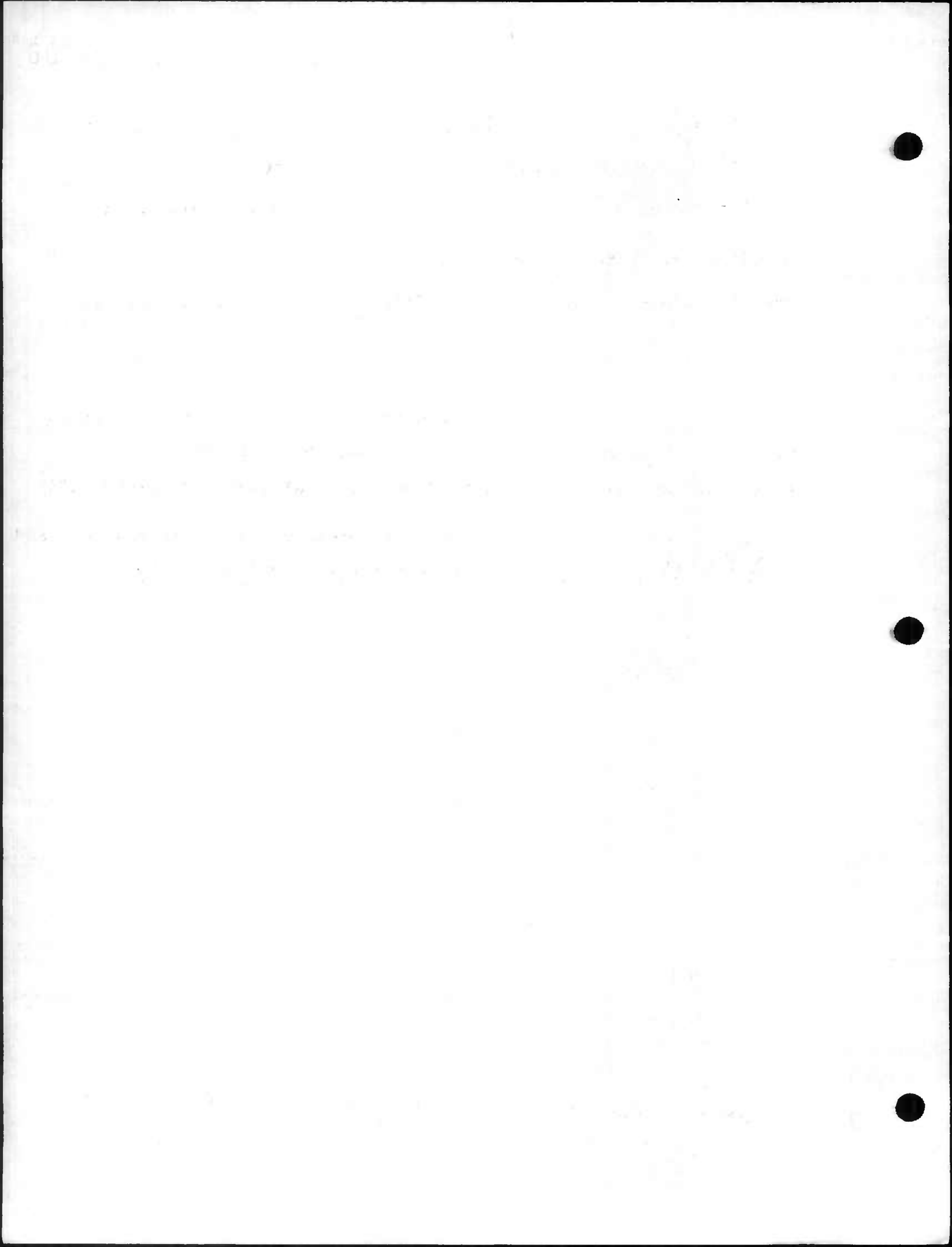
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3



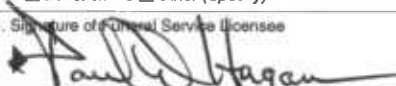

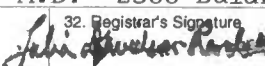
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14509

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Rudd</b>				2. Date of Death Month <b>May</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>2:45 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Dulaney Valley</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>130-14-6778</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 16, 1904</b>	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>305 East Joppa Road</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>teacher</b>		16b. Kind of Business/Industry <b>private school</b>				
	17. Father's Name (First, Middle, Last) <b>David Palmer Barrett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Olyn Reid</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>P. Barrett Rudd, son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21093</b> <b>1601 Riderwood Drive Lutherville, Maryland</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>5/16/96</b>		20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. Arbutus</b> <b>1328 Sulphur Spring Road 21227</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ENDSTAGE DEMENTIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Kendall Faulkner, M.D.</b>						29c. License number <b>D25643</b>	
29d. Date signed (Month, Day, Year) <b>5/16/96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kendall Faulkner, M.D. 2300 Dulaney Valley Road, Towson, MD 21204</b>							
31. Date filed (Month, Day, Year) <b>MAY 18 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14510

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Joseph Seivold, Sr.

2. Date of Death

Month Day Year  
May 14, 1996

3. Time of Death

7:50 AM

4a. Facility Name (If not institution, give street and number)

Meridian Nursing Home-Towson

4b. City, Town, or Location of Death

Toswon

4c. County of Death

Baltimore County

Funeral  
Director

5. Social Security Number

579-18-1881

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 9, 1903

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedant

10a. State

MD

10b. County

Carroll County

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6100 Bartholow Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

17. Father's Name (First, Middle, Last)

Joseph Seivold

18. Mother's Name (First, Middle, Maiden Surname)

Mary Becsei

19a. Informant's Name/Relationship (Type, Print)

Mr. Joseph Seivold, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18901 Middletown Road Parkton, MD 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wesley Freedom Cemetery

Date

5/18/96

20c. Location - City or Town, State

Eldersburg, MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (P.O. Box 195)  
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASHD = CHF  
Dua to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CA PROSTATE

UTI

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending

29c. License number

D17118

29d. Date signed (Month, Day, Year)

5/14/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Old Court Rd Suite 203 Baltimore, Md 21208

31. Date filed (Month, Day, Year)

MAY 18 1996

32. Registrar's Signature

John Michael Ravelle

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

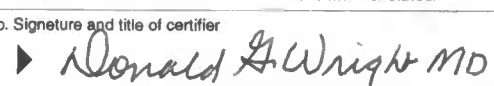
The first thing I noticed when I stepped out  
 of the car was the cold. It was a sharp  
 contrast to the warm blanket I had been  
 wrapped in. The air was crisp and clear,

and it felt like a fresh start.

jhm ITEMS: 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene 96 14511  
 FILM g-737 7/5/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KEYON ANDERSON</b>				2. Date of Death <b>MAY 16, 1996</b>		3. Time of Death <b>07:34 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-45-8706</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>2</b> Months <b>29</b> Days		8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1996</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>602 N. Kenwood Avenue</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>BABY</b> College (1-4 or 5+) <b>BABY</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>N/A</b>	
	17. Father's Name (First, Middle, Last) <b>Christopher Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Antionette Anderson</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Antionette Anderson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 N. Kenwood Avenue, Baltimore, MD 21205</b>			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		Date <b>5-20</b>		20c. Location - City or Town, State <b>RANDALLSTOWN, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Baltimore, MD 21202</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14512

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH T. ALLMAN</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>15</b> YEAR <b>96</b>		3. TIME OF DEATH <b>8:00 A M</b>				
4. SOCIAL SECURITY NUMBER <b>212-07-2059</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/15/10</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Medbridge Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>				
RESIDENCE OF DECEDENT										
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>6600 Ridge Road</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>unknown</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Telephone Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Charles Thompson Allman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mamie Weaver Allman</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Charles Allman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501 Ellsworth Place, Joppa, MD 21085</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade</i> <b>Ronald S. Wade, Dir.</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201-1559</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmias</b> Approximate Interval Between Onset and Death <b>1 1/2 hr.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td>b. <b>Possible myocardial infarction</b></td> <td><b>1 hr</b></td> </tr> <tr> <td>c. <b>Dilated and ischemic Cardiomyopathy</b></td> <td><b>2-3 yrs</b></td> </tr> </table>							b. <b>Possible myocardial infarction</b>	<b>1 hr</b>	c. <b>Dilated and ischemic Cardiomyopathy</b>	<b>2-3 yrs</b>
b. <b>Possible myocardial infarction</b>	<b>1 hr</b>									
c. <b>Dilated and ischemic Cardiomyopathy</b>	<b>2-3 yrs</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>① Renal failure. ② Severe malnutrition ③ Anemia.</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED						
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. A. Seese</i> <b>M.D.</b>				29c. LICENSE NUMBER <b>D-38754</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-15-96</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MALIKA WASBEM. 100. N. BROADWAY, BALTIMORE, MD - 21231</b>										
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11211 03

11211 03

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14513

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carmen Alvarado				2. Date of Death Month Day Year May 17, 1996		3. Time of Death 8:30 A.M.		
	4a. Facility Name (If not institution, give street and number) 14826 Belle Ami Drive				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George		
Funeral Director	5. Social Security Number 286-50-9818	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 28, 1937		9. Birthplace (State or Foreign Country) Panama	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Prince George	10c. City, Town or Location Laurel			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 14826 Belle Ami Drive			10f. Zip Code 20707		10g. Citizen of What Country? Panama			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Chinese		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transcriber			16b. Kind of Business/Industry Medical			
	17. Father's Name (First, Middle, Last) Ho Chong Man				18. Mother's Name (First, Middle, Maiden Surname) Lee See Ho				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kira Fiutak / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14826 Belle Ami Drive, Laurel, Maryland 20707					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Cr.		Date 5/18		20c. Location - City or Town, State Laurel, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Squamous cell cancer of lung/metastatic bronchitis Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
	23b. Enter the date, or dates, of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 			29c. License number D23743			29d. Date signed (Month, Day, Year) 5-17-96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARTIN D. WEITZ 7525 Greenway Ct On Greenbelt MD 20720									
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature 							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14514

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS Margaret AMEY				2. Date of Death Month Day Year MAY 16, 1996		3. Time of Death 12:56 PM			
	4a. Facility Name (If not institution, give street and number) 444 NORTH ROBINSON STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
Funeral Director	5. Social Security Number 217-12-5722		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 8, 1916	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 444 North Robinson Street				10f. Zip Code 21224		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Elmer Lyon Amey				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Krapp					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Robert N. Amey / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 Woodhome Avenue Baltimore, Maryland 21234					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 5/18/96		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Mark T. Zavoyna Mark T. Zavoyna				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214					
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Donald G. Wright MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 16, 1996						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature G. Davidson-Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14515

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Samettra Booker</b>				2. Date of Death Month <b>May</b> Day <b>14</b> , 1996 Year		3. Time of Death <b>4:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-68-2217</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 22, 1957</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1967 Ewald Avenue</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>		College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Samuel Toliver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Davis</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Emory L. Booker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1967 Ewald Avenue, Baltimore, MD 21222</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park Cem.</b>		Date <b>5-20-96</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>	
	21. Signature of Funeral Service Licensee <b>L. Valencia Holland</b>				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>			
Physician /Medical Examiner	23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Leiomyosarcoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>5 Months</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kalpana V. Char, MD</b>		29c. License number <b>D47740</b>		29d. Date signed (Month, Day, Year) <b>May 15, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kalpana V. Char M.D.</b>		31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>						
32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Title <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death within Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALICE BRENNAN ALICE WHALEN BRENNAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>19</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0955 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>208-16-5293</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR 15, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6882 Garland Lane</b>				10f. ZIP CODE <b>21045</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Patrick Daley, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gwendolyn Lloyd</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William James Brennan/Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6882 Garland Ln. Columbia, MD 21045</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Metro Crematory, Inc. 5/2/96</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>		20d. DATE <b>5/2/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's Dementia</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29b. LICENSE NUMBER <b>D-34868</b>		29c. DATE SIGNED (Month, Day, Year) <b>MAY 19, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALICE BRENNAN 11055 LITTLE PATRICK PARKWAY COLUMBIA, MD 21044</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maria Bozzelli				2. Date of Death Month Day Year May 19 1996		3. Time of Death 6:15pm													
	4a. Facility Name (If not institution, give street and number) Manor Care of Towson				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore													
Funeral Director	5. Social Security Number 216-36-8924		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March 27, 1908	9. Birthplace (State or Foreign Country) Italy												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location n/a		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 8602 Delegge Road				10f. Zip Code 21237		10g. Citizen of What Country? Italy													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tailor		16b. Kind of Business/Industry Tailor Shop													
	17. Father's Name (First, Middle, Last) Giusseppe (unk)				18. Mother's Name (First, Middle, Maiden Surname) Agata (unk)															
	19a. Informant's Name/Relationship (Type, Print) Daughter Jessime D'Amato				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8602 DeLegge Road Baltimore, Md. 21237															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus		Date 5/22/96		20c. Location - City or Town, State Baltimore, Md.													
	21. Signature of Funeral Service Licensee <i>Joseph N. Zannino Jr.</i>				22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Baltimore, Md. 21224															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ACUTE CARDIAC ARRHYTHMIA</td> <td>MINUTES</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY INSUFFICIENCY</td> <td>20 YEARS</td> </tr> <tr> <td>c.</td> <td>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</td> <td>20 YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE CARDIAC ARRHYTHMIA	MINUTES	b.	CORONARY ARTERY INSUFFICIENCY	20 YEARS	c.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	20 YEARS	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE CARDIAC ARRHYTHMIA	MINUTES																	
	b.	CORONARY ARTERY INSUFFICIENCY	20 YEARS																	
	c.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	20 YEARS																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <i>Joseph D. Notarangelo M.D.</i>				29c. License number DO 7316		29d. Date signed (Month, Day, Year) MAY 20 1996														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE MD 21202																				
31. Date filed (Month, Day, Year) MAY 20 1996				32. Registrar's Signature <i>Davidson</i>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

17

24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500

501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700

701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14518

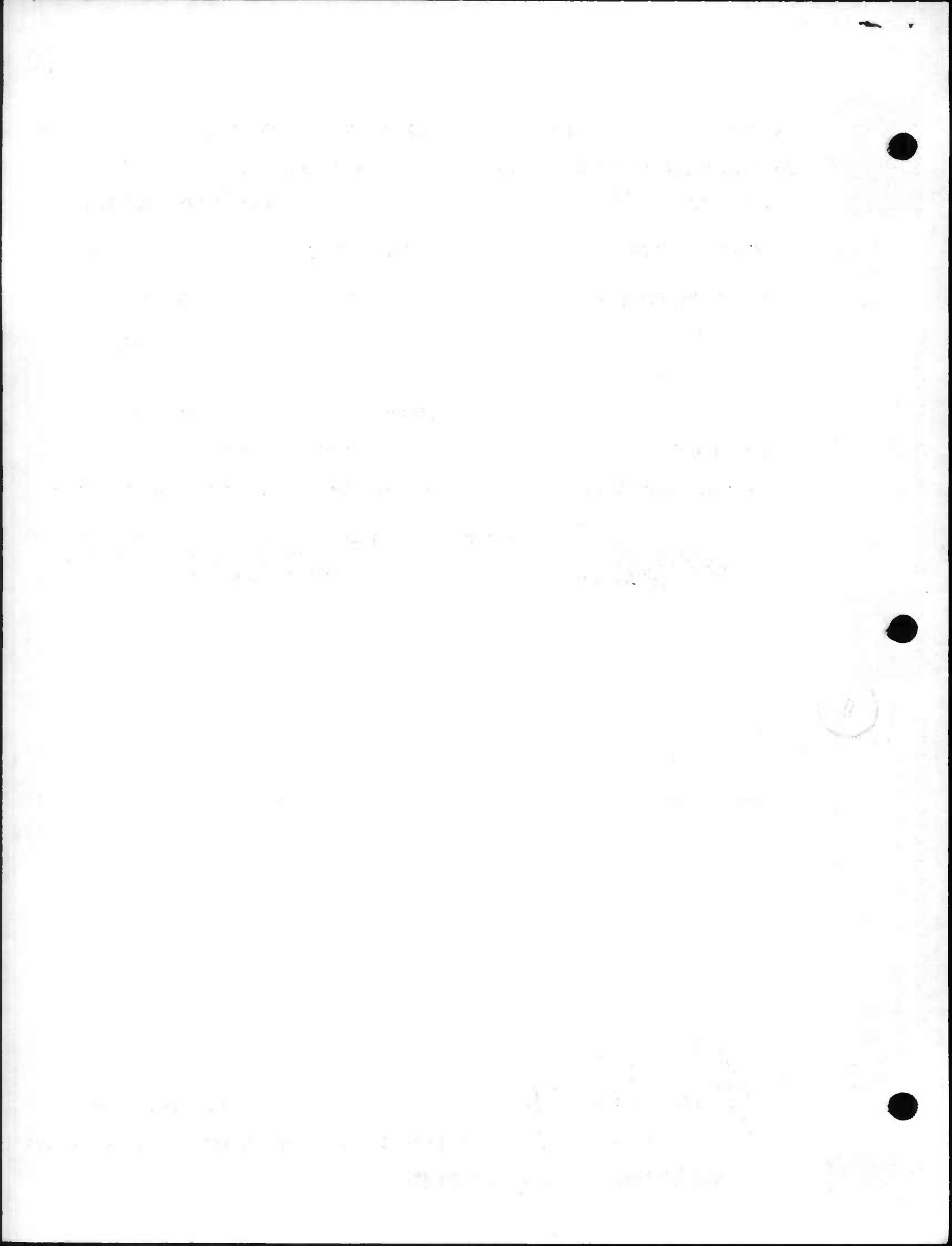
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTONIO LEWIS BROWN SR.</b>				2. Date of Death Month Day Year <b>MAY 14, 1996</b>		3. Time of Death <b>0015AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3012 SOUTHLAND AVENUE--LAWN</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-90-1518</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>25</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 26 1970</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	10a. State <b>MARYLAND</b>				10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>2910 SOUTHLAND AVENUE</b>				10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th grade</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Demolition</b>		16b. Kind of Business/Industry <b>Contractural</b>				
	17. Father's Name (First, Middle, Last) <b>William Gamble</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vivian D. Brown</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ramona L. Brown/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2910 Southland Avenue, Baltimore, Maryland 21225</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. Location - City or Town, State <b>5-21-96 Baltimore, Maryland</b>				
	21. Signature of Funeral Director <i>[Signature]</i>				22. Name and Address of Facility <b>WILLIAM C. BROWN COMM. F/H 1206 W. NORTH AVENUE</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Gunshot Wounds</b> Due to (or as a consequence of):  <b>b. Due to (or as a consequence of):</b>  <b>c. Due to (or as a consequence of):</b>  <b>d. Due to (or as a consequence of):</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>5-14-96</b>		28b. Time of Injury <b>0007 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3012 Southland Ave</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 14519

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret B. Baer				2. DATE OF DEATH MONTH DAY YEAR May 15 1996		3. TIME OF DEATH 2:15 A M	
4. SOCIAL SECURITY NUMBER 218-05-1903		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 31 1915	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 212 Gittings Ave.	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) William H Bass				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sally			
19a. INFORMANT'S NAME (Type/Print) Curtis Baer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Gittings Ave. Baltimore, Md. 21212			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 5/20/96		20c. LOCATION — City or Town, State Towson, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Stroke</u> <u>Peripheral Vascular Disease</u> <u>Chronic Atrial Fibrillation</u> <u>Chronic Osteomyelitis</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate interval Between Onset and Death 1 wk 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation a <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William D. McConnell MD				29c. LICENSE NUMBER 042129		29d. DATE SIGNED (Month, Day, Year) 5-15-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. McConnell 500 W. University Baltimore 21210							
31. DATE FILED (Month, Day, Year) MAY 20 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL MALACHI ALI</b>				2. Date of Death Month <b>May</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>12:36</b>	
	AKA <b>Samuel MALACHI Cook-Bey</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>538-98-1128</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>19</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/05/76</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Columbia</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>5981 Turnabout Lane</b>				10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>Education</b>	
	17. Father's Name (First, Middle, Last) <b>Ronald Cook-Bey</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Behira Said</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Behira Said - Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5981 Turnabout Lane, Baltimore, MD 21044</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Data <b>5/16/96</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie F/F PA</b> <b>638 N. Gilmer Street 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Hanging</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Found 5/11/96</b>		28b. Time of Injury <b>FOUND 12:15Hrs</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28d. Describe how injury occurred <b>Hanged Self</b>				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Balto., MD</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>2245 Reisterstown Rd</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>May 12, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald G. Wright MD 111 Penn St. Balto. MD 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

11-11-11

11-11-11

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14521

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <u>Romaine Cameron</u>					2. Date of Death Month <u>May</u> Day <u>16</u> Year <u>1996</u>		3. Time of Death <u>0935A</u>		
	4a. Facility Name (If not institution, give street and number) <u>Mercy Hospital</u>					4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>		
<b>Funeral Director</b>	5. Social Security Number <u>216-34-0117</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>58</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Sept. 10, 1937</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent									
10a. State <u>Maryland</u>			10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <u>3114 Ellerslie Avenue</u>					10f. Zip Code <u>21218</u>		10g. Citizen of What Country? <u>United States</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th</u> College (1-4 or 5+) <u>-</u>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housewife</u>			16b. Kind of Business/Industry <u>private home</u>		
17. Father's Name (First, Middle, Last) <u>William Hardy</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>RUBY DE SHEILDS HARDY</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Kevin Cameron</u>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6037 Marquette Road, Baltimore, MD 21206</u>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		Date <u>5-20-96</u>		20c. Location - City or Town, State <u>Anne Arundel Co, MD</u>			
21. Signature of Funeral Service Licensee <u>[Signature]</u>					22. Name and Address of Facility <u>March Funeral Home</u> <u>1101 E. North Avenue, Baltimore, MD 21202</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Pulmonary Embolism</u> Due to (or as a consequence of): b. <u>Deep Venous Thrombosis</u> Due to (or as a consequence of): c. <u>Lymphoma</u> Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Gastritis, Esophagitis</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <u>[Signature] MD</u>					29c. License number <u>P09129</u>		29d. Date signed (Month, Day, Year) <u>May 16, 1996</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Michael Bond, 301 St. Paul Place Baltimore MD 21202</u>										
31. Date filed (Month, Day, Year) <u>MAY 20 1996</u>										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14522

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>EDDIE L. CHEEKS</b>						2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>96</b>		3. Time of Death <b>4:55 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS MERCY HOSPICE</b>						4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>						
<b>Funeral Director</b>	5. Social Security Number <b>219-66-6031</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 13 1956</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
	Usual Residence of Decedent														
<b>To Be Completed by Funeral Director</b>	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number <b>1812 RUTLAND AVENUE</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>								
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>MANAGER</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER</b>			16b. Kind of Business/Industry <b>RESTAURANT</b>							
	17. Father's Name (First, Middle, Last) <b>Eddie Thomas Alston</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Lee Brown</b>								
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Edward L. Cheeks/Twin Brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2910 W. Coldspring Lane Apt C. Baltimore Maryland 21215</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>			Data <b>5-17-96</b>		20c. Location - City or Town, State <b>BALTIMORE MARYLAND</b>						
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of):  b. <b>HIV INFECTION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death  <b>UNKNOWN</b>  <b>UNKNOWN</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number <b>D40480</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO J. FERRO, MD</b>						30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5810 BELAIR RD BALTO., MD 21206</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14523

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN F. CZYZ				2. Date of Death Month Day Year MAY 17 1996		3. Time of Death 1 PM	
	4e. Facility Name (If not institution, give street and number) 7802 FLAGSTAFF ROAD				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-20-3875	6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-22-27	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7802 Flagstaff Rd.				10f. Zip Code 21237		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist			16b. Kind of Business/Industry Martin Marietta	
17. Father's Name (First, Middle, Last) Stephen Cxyz				18. Mother's Name (First, Middle, Maiden Surname) Josephine Gadowicz				
19e. Informant's Name/Relationship (Type, Print) Virginia Cxyz / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7802 Flagstaff Rd. Baltimore, MD 21237				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary		Data 5-20-96	20c. Location - City or Town, State Dundalk, MD		
21. Signature of Funeral Service Licensee Denise S Kelly				22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Baltimore, MD 21237				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Rectal Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. left leg Deep venous thrombosis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Gayatri Nimmagadda						
		29c. License number D39041		29d. Date signed (Month, Day, Year) May 17 <sup>th</sup> 1996.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAYATRI NIMMAGADDA Harbor Hospital Center Baltimore MD.								
31. Date filed (Month, Day, Year) MAY 20 1996				32. Registrar's Signature Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24e show any injury or other traumatic event, the Medical Examiner must be notified at once.

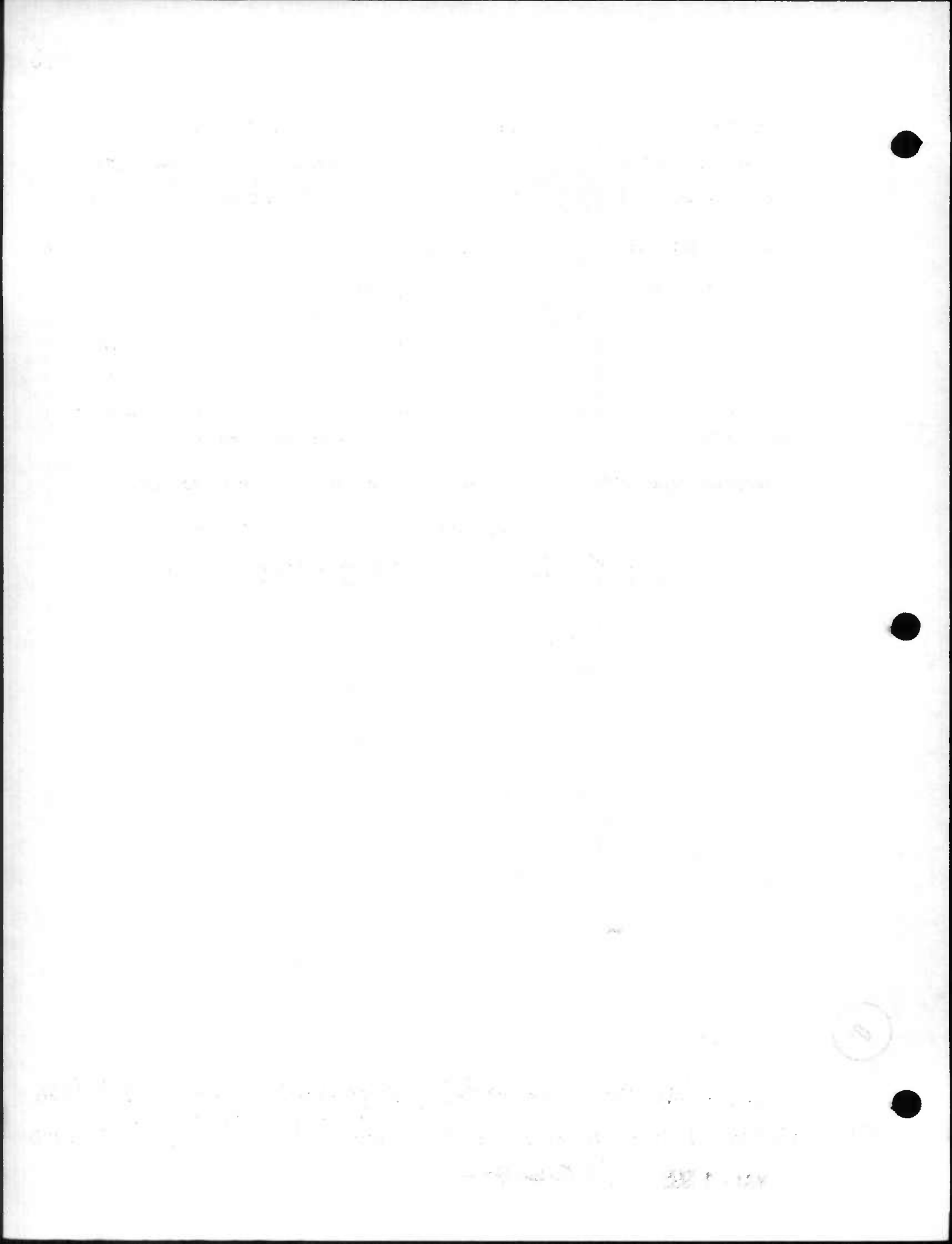
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14524

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VINCENT CEPHAS (MN-LEE)</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>5:00 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>218-78-7170</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 29, 1960</b>					
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CAMDEN VARDS NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>					
9c. COUNTY OF DEATH <b>BALTIMORE</b>				RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1217 W. FAYETTE STREET</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>					
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11+ GRADE</b> College (1-4 or 5+) <b>UNEMPLOYED</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NIA</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>HENRY F. CEPHAS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIVIAN JOHNSON</b>							
19a. INFORMANT'S NAME (Type/Print) <b>VIVIAN STONE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>704 GILMORE STREET, BALTIMORE, MD. 21217</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 5-17-96</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. End stage renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. AIDS</b> <b>c. Endocarditis</b> <b>d. Seizures</b> DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AIDS</b> <b>Seizures</b> <b>Endocarditis</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <b>3</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO					
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D27569</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/16/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Allen Bettlemann 1777 Rusterstown Rd #305</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14525

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer J. Cook				2. Date of Death Month Day Year May 14 1996		3. Time of Death 0804AM	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital 301 Hospital Dr				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213-10-8587		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 01, 1911	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County A.A. COUNTY		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 316 MARLEY NECK ROAD		10f. Zip Code 21060		10g. Citizen of What Country? USA.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 <sup>th</sup> GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry TRUCKING COMPANY		16c. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) ZIBER		18. Mother's Name (First, Middle, Maiden Surname) COOK JOSEPHINE BROOKS		19. Informant's Name/Relationship (Type, Print) DEANA CURTIS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167 MORRIS CT, GLEN BURNIE, MD. 21060	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Location - City or Town, State 5-17-96 GLEN BURNIE, MD.		20d. Date	
	21. Signature of Funeral Service Licensee <i>Joseph H. Brown Jr.</i>		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME P.A. 2140 N. FULTON AVE, BALTIMORE, MD. 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>renal failure</i> Due to (or as a consequence of):  b. <i>prostate cancer</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death ~ 3mo ~ 6mo	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Loraine M. Dailey, M.D.</i>		29c. License number D21613		29d. Date signed (Month, Day, Year) 5/16/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Loraine M. Dailey, M.D. 8096 Edwin Raynor Blvd Pasadena, MD 21122							
State Registrar	31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature <i>John R. ...</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14526

ITEM 4C FILM G735 5/20/96ag perFH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Cohen</b>				2. Date of Death Month <b>May</b> Day <b>19th</b> Year <b>1996</b>		3. Time of Death <b>12:00 noon</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore N/A</b>	
Funeral Director	5. Social Security Number <b>187-07-4482</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 4, 1916</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Pennsylvania</b>		10b. County <b>Lehigh</b>		10c. City, Town or Location <b>Whitehall</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1203 Olympic Circle South</b>				10f. Zip Code <b>18052</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Aaron Aronsky</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Rose Grossman</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Charles Cohen / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>192 Alexander Ave. Nutley, New Jersey 07110</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Keneseth Israel Cemetery</b>		Date <b>5/19/96</b>		20c. Location - City or Town, State <b>South Whitehall Twp., PA</b>	
	21. Signature of Funeral Service Licensee <b>Mark T. Zavovna</b>				22. Name and Address of Facility <b>5305 Harford Road Leonard J. Ruck, Inc. Balto., MD 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Malignant Brain Tumor</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>~ 3 weeks</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	28f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28g. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Laurence D. Rhines, M.D.</b>		29c. License number <b>69481</b>	
	29d. Date signed (Month, Day, Year) <b>May 19, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laurence Rhines Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD</b>			
	31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature <b>John A. ...</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14527

ITEM#1 film g735 5/20/96 ag perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FANNIE <del>K</del> <del>DRAKSLER</del> KRALL-DRAKSLER</b>				2. Date of Death Month Day Year <b>MAY 16 1996</b>		3. Time of Death <b>10:04 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Church Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212 42 5299</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>101</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07 29 94</b>	9. Birthplace (State or Foreign Country) <b>Austria-Hungary</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>412 South Macon Street</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>Unknown</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housework</b>			16b. Kind of Business/Industry <b>At Home</b>	
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Joseph Krall, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1318 Broadview Blvd. Glen Burnie, Md. 21061</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. Location - City or Town, State <b>5-20-96 Eastwood, Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave., Balto., Md.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>MULTIPLE ORGAN FAILURE</b>								Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE ORGAN FAILURE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  M.D.		29c. License number <b>D 26594</b>		29d. Date signed (Month, Day, Year) <b>May 16 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RIAZ BOKHARI M.D. 100 NORTH BROADWAY BALTIMORE MD 21231</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14528

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA C. DRZEWIECKI				2. Date of Death Month Day Year 5 11 96		3. Time of Death 5:00PM	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTO. CO.	
Funeral Director	5. Social Security Number 217-14-9578		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 10-22-18	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2525 FAIT AVENUE		10f. Zip Code 21224		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YEARS College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) SALVATORE VERO				18. Mother's Name (First, Middle, Maiden Surname) AMELIA AMARILLI			
	19a. Informant's Name/Relationship (Type, Print) MR. WALTER DRZEWIECKI				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2129 N. CHARLES ST. BALTO. MD. 21218			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEM.		20c. Location - City or Town, State 5-14 BALTO. MD.			
	21. Signature of Funeral Service Licensee Charles R. Kaczorowski				22. Name and Address of Facility KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21224			
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cerebrovascular Accident Due to (or as a consequence of): b. Chronic Renal Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier C. Rame				29c. License number D30641		29d. Date signed (Month, Day, Year) 5/16/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH SABARWAL MD 3400 Erdman Ave Baltimore MD 21218								
31. Date filed (Month, Day, Year) MAY 20 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14529

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY DEDMON (MN-WALLACE)

2. Date of Death

May 13 1996

3. Time of Death

7:45pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

218-44-9867

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR. 31, 1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

31 GORMAN AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WINDOW WASHER

16b. Kind of Business/Industry

WINDOW WASHING CO.

17. Father's Name (First, Middle, Last)

AMOS

WALLACE

18. Mother's Name (First, Middle, Maiden Summa)

EDITH

DEDMON

19a. Informant's Name/Relationship (Type, Print)

EDITH DEDMON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 GORMAN AVE., BALTIMORE, MD. 21223

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

5-16-96

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.

2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Streptococcus/Pneumococcal Pneumonia/Sepsis 10 day

Due to (or as a consequence of):

b. ARDS (Adult Respiratory distress Syndrome)

Due to (or as a consequence of):

c. Hemorrhagic Brain accident.

Due to (or as a consequence of):

d. HIV - AIDS

Approximate Interval Between Onset and Death

3 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

A52402321/5B/9701

29d. Date signed (Month, Day, Year)

May, 13 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge L Baez - Sinai Hospital, Baltimore City, Maryland.

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

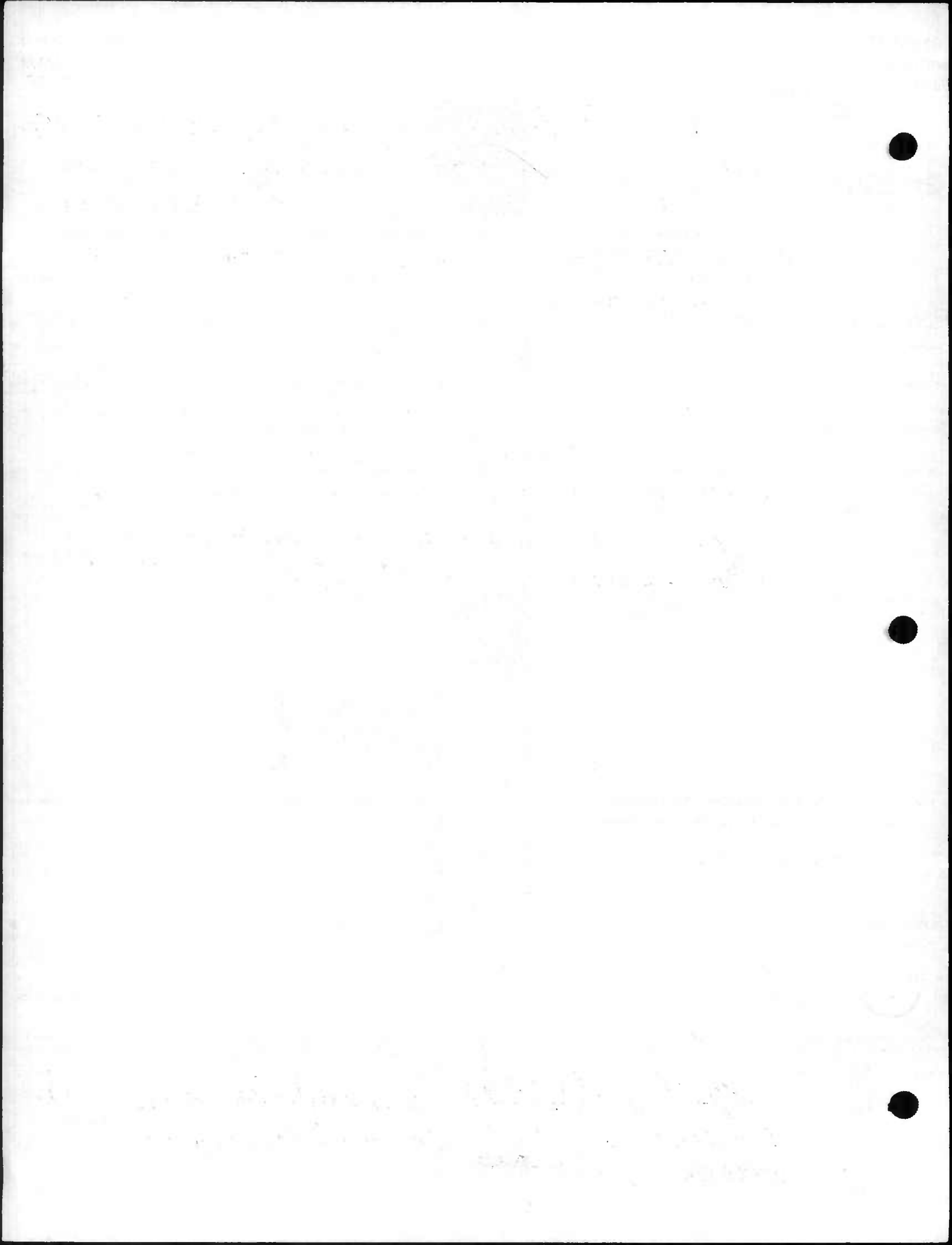
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14530

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wilson Davis</b>				2. Date of Death Month <b>May</b> Day <b>12th</b> Year <b>1996</b>		3. Time of Death <b>4:15pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>246-16-8866</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 26, 1921</b>	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10e. Street and Number <b>2003 PENROSE AVENUE</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CEMENT FINISHER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION CO.</b>		
17. Father's Name (First, Middle, Last) <b>JOHN D. DAVIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MATTIE BUIE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARY JOHNSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11107 DOYLE BLVD, MCKENNY, VA. 23872</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BIG BETHEL BURIAL PARK 5-17-96 MCKENNY, VIRGINIA</b>		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Joseph H BROWN III</b>				22. Name and Address of Facility <b>JOSEPH H. BROWN FUNERAL HOME 2140 N. FULTON AVE, BALTO. MD. 21217</b>				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <b>Respiratory failure</b> Due to (or as a consequence of):								<b>2 weeks.</b>
b. <b>Esophageal Cancer with Metastasis</b> Due to (or as a consequence of):								<b>6 months.</b>
c. <b>Congestive heart Failure</b> Due to (or as a consequence of):								
d. <b>Coronary artery disease</b> Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Edward Chazee MD</b>				29c. License number <b>DH4430</b>		29d. Date signed (Month, Day, Year) <b>May 12th 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bonsecours Hospital 2000 West Baltimore St Baltimore</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature <b>Wilson-Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

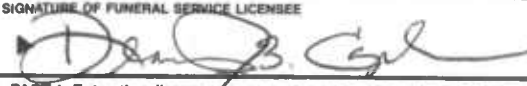

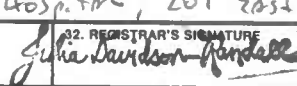
Medical Certification: To Be Completed by Physician/Medical Examiner



96 14531

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Leon Edmondson, Sr.				2. DATE OF DEATH MONTH DAY YEAR May 16 1996		3. TIME OF DEATH 0630a M	
4. SOCIAL SECURITY NUMBER 228-24-8972		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 12, 1927	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA		9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MD.				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3419 TERESA COURT				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11/15/50 04/21/52		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER		16b. KIND OF BUSINESS/INDUSTRY DEMOLITION			
17. FATHER'S NAME (First, Middle, Last) AA ARTHUR LEE EDMONDSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLA BOWMAN			
19a. INFORMANT'S NAME (Type/Print) GLADYS EDMONDSON (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 TERESA COURT BALTIMORE, MD. 21213			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 5/17/96		20c. LOCATION — City or Town, State CATONSVILLE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTO, MD. 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diverticulosis DUE TO (DR AS A CONSEQUENCE OF): b. Hypertension DUE TO (DR AS A CONSEQUENCE OF): c. Stroke DUE TO (DR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval Between Onset and Death Hours Years Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER  Edna Hill M.D.				29c. LICENSE NUMBER D36786		29d. DATE SIGNED (Month, Day, Year) MAY-17-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Union Memorial Hospital, 201 East University Parkway, Balt. MD 21218-2895							
31. DATE FILED (Month, Day, Year) MAY 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14532

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lena M. Earling</b>				2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>1:57 AM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Ivy Hall Geriatric Center</b>				4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>214-44-5299</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>May 10, 1903</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yaa 2 <input checked="" type="checkbox"/> No			
10a. Street and Number <b>9803 Bird River Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Carl Keller</b>					16. Mother's Name (First, Middle, Maiden Summa) <b>Lena Berkes</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Shirley Brown (DAUGHTER)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>947 Lance Avenue Essex, Md. 21221</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>5/18/1996</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ASPIRATION PNEUMONIA</b> Due to (or as a consequence of):  b. <b>DEMENTIA</b> Due to (or as a consequence of):  c. <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 DAYS</b>  <b>YEARS</b>  <b>YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>OVARIAN MASS, OSTEOARTHRITIS</b>  <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  <b>D.O.</b>			29c. License number <b>H35593</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MD. 21221</b>											
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14533

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace M. Evans				2. Date of Death Month May 16 Day 1996		3. Time of Death 1:55 PM		
	4a. Facility Name (If not institution, give street and number) 2715 Mt. Carmel Road				4b. City, Town, or Location of Death Parkton		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-26-3758	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 13, 1930		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore		10c. City, Town or Location Parkton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2715 Mt. Carmel Road			10f. Zip Code 21120		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) George Masters				18. Mother's Name (First, Middle, Maiden Summa) Wilhelmina Schoen				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathryn Evans-Knoblock			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19600 Gott Street Poolesville, Maryland 20837					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory May 17, 1996		Data		20c. Location - City or Town, State Catonsville, Maryland		
	21. Signature of Funeral Service Licensee Guanta R. Thomas			22. Name and Address of Facility Witzke Funeral Homes Inc. 1630 Edmondson Avenue Catonsville, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. end stage renal disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximately Interval Between Onset and Death 5 days > 3 yrs								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Nancy L. Grass MD		29c. License number VA.# 0116006916		29d. Date signed (Month, Day, Year) 17 MAY 96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy L. Grass WRAMC Dept of medicine Washington DC 20207									
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature Julia Sedison-Rodriguez							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14534

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Dorothy Virginia Freburger</u>				2. Date of Death Month <u>5</u> Day <u>12</u> Year <u>96</u>		3. Time of Death <u>1030 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Sinai Hosp. Balto 2401 N Belvedere Av Balto MD</u>				4b. City, Town, or Location of Death <u>Balto MD</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>219-10-1217</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>69</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>June 10, 1926</u>	9. Birthplace (State or Foreign Country) <u>MD</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Rosedale</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>7936 Berk Lane</u>				10f. Zip Code <u>21237</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Check Process. &amp; Inspect</u>			16b. Kind of Business/Industry <u>Bank Stationary</u>	
17. Father's Name (First, Middle, Last) <u>Jennings L. Ament Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Fitch</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Joseph Leo Freburger Jr/Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7936 Berk Lane Rosedale, MD 21237</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Highview</u>		Date <u>05/16/96</u>		20c. Location - City or Town, State <u>Fallston, MD</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>CVACH/ROSEDALE FUNERAL HOME</u> <u>1211 Chesaco Avenue 21237</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. <u>respiratory failure</u> Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>septic shock</u> Due to (or as a consequence of):								
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Deanne Mc. Kenzie MD</u>		29c. License number <u>AS402321 DM9930</u>		29d. Date signed (Month, Day, Year) <u>5/12/96</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Deanne McKenzie MD 2401 N. Belvedere Ave</u>								
31. Date filed (Month, Day, Year) <u>MAY 20 1996</u>		32. Registrar's Signature <u>[Signature]</u>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 14535

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Fuchs, Sr.</b>				2. DATE OF DEATH MONTH <b>May</b> , DAY <b>17</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>1:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-36-5975</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>95</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 30, 1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Eastpoint Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>2116 Tred Avon Road</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Light House Service</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Coast Guard</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Stephen Fuchs, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Slivka</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John A. Fuchs, Jr. (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2116 Tred Avon Rd. Essex, Md. 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens Of Faith Cemetery May 20, 1996</b>		20c. LOCATION — City or Town, State <b>Baltimore, Co. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdziński Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Arteriosclerotic Heart Disease</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>Arteriosclerosis</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b></b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d. <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>011150</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/17/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



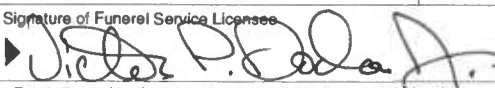


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14536

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James M. Flynn</b>						2. Date of Death Month <b>May</b> 19, Day <b>19</b> , Year <b>1996</b>		3. Time of Death <b>2:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1423 Hull Street</b>						4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-01-1192</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 12, 1900</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1423 Hull Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Longshoreman</b>				16b. Kind of Business/Industry <b>Shipping</b>		
17. Father's Name (First, Middle, Last) <b>Michael J. Flynn</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary O'Hara</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Michael J. Flynn / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Anderson Ridge Road, Baltimore, Maryland 21228</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery, May 22, 1996</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>acute + chronic renal Failure</b> Due to (or as a consequence of): b. <b>congestive heart Failure</b> Due to (or as a consequence of): c. <b>ASCD</b> Due to (or as a consequence of): d.										1yr 5yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic atrial fibrillation</b> <b>type II maturity Onset Diabetes mellitus</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  <b>Glen E. Johnson MD</b>		29c. License number <b>D 19558</b>		29d. Date signed (Month, Day, Year) <b>5-20-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Glen E. JOHNSON, MD 716 MAIDEN CHOICE LN BALTIMORE, MD 21228</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The last certifier that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1947.11.22

Dear Mr. [Name] :

I have received your letter of the 11th inst.

and am sorry to hear that you are not satisfied with the results of the test.

I am sure that the results are correct and that the test was conducted properly.

I am sorry that you are not satisfied with the results and I am sure that you will be satisfied with the results of the next test.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

I am sure that the results of the next test will be satisfactory.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14537

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Elizabeth Geddes</b>				2. Date of Death Month <b>May</b> Day <b>16</b> , Year <b>1996</b>		3. Time of Death <b>11:52 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Roland Park Place</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-38-4442</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 15, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>830 W. 40th Street</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>WW II</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>MD State Government</b>		17. Father's Name (First, Middle, Last) <b>William Lee Geddes</b>	
	17. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Campbell</b>		19a. Informant's Name/Relationship (Type, Print) <b>Patricia W. Strawbridge/Cousin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2126 Old Frederick Rd. Catonsville, MD 21228</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 5/17/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <b>George E. MacNabb</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dementia</b> Due to (or as a consequence of): <b>b. Multiple CVA's</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Medical Examiner</b>		29c. License number <b>D33072</b>	
	29d. Date signed (Month, Day, Year) <b>May 17, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Caesar C. Shediak, M.D. 3333 N. Calvert St., Suite 575 Balto., MD 21218</b>		31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature <b>Davidson-Randall</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death while the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar





96-2563-510

ITEM: 23 PART I, PER MEO FILM g-739 9/9/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f, PER State of Maryland / Department of Health and Mental Hygiene  
MEO FILM G-735 5/29/96 t.t

## Certificate of Death

Reg. No.

96 14538

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

the hospital or attending physician: The law requires that the death certificate be executed within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>CLARENCE</b>				2. Date of Death Month <b>MAY</b> Day <b>11</b> Year <b>1996</b>				3. Time of Death <b>8:41 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>BON SECOUR HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-50-2012</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 22, 1952</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1411 DIVISION STREET</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>CONSTRUCTION</b>		
17. Father's Name (First, Middle, Last) <b>EZEKIEL W. HURST</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE COOPER</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LEONARD HURST (BROTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53934 1041 CREE AVENUE FRIENDSHIP, WISCONSIN</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. AUBURN CEM</b>		Date <b>5/20/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTIMORE, MD. 21215</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METHADONE INTOXICATION COMPLICATING ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)</b> Dua to (or as a consequence of):  <b>b.</b> Dua to (or as a consequence of):  <b>c.</b> Dua to (or as a consequence of):  <b>d.</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5/11/96</b>		28b. Time of Injury <b>UNKNOWN</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <b>UNKNOWN</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>MAY 12, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>									
32. Registrar's Seal 									

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14539

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KATHLEEN

HOSMER

2. Date of Death  
Month Day Year

MAY

10,

1996

3. Time of Death  
4:45 P.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

278-22-9409

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

April 21, 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street end Number

2300 Dulaney Valley Road

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

n/a

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Howard Sdout

18. Mother's Name (First, Middle, Maiden Surname)

Cannie Van Horn

19a. Informant's Name/Relationship (Type, Print)

Earl Hosmer, husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

7429 Berkshire Road, Baltimore, MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wada, Dir.

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore St.

Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. BRAIN METASTASES

Due to (or as a consequence of):

b. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7yrs.

40yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28e. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury et  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Kendall R Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

5/13/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

Julia Thompson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

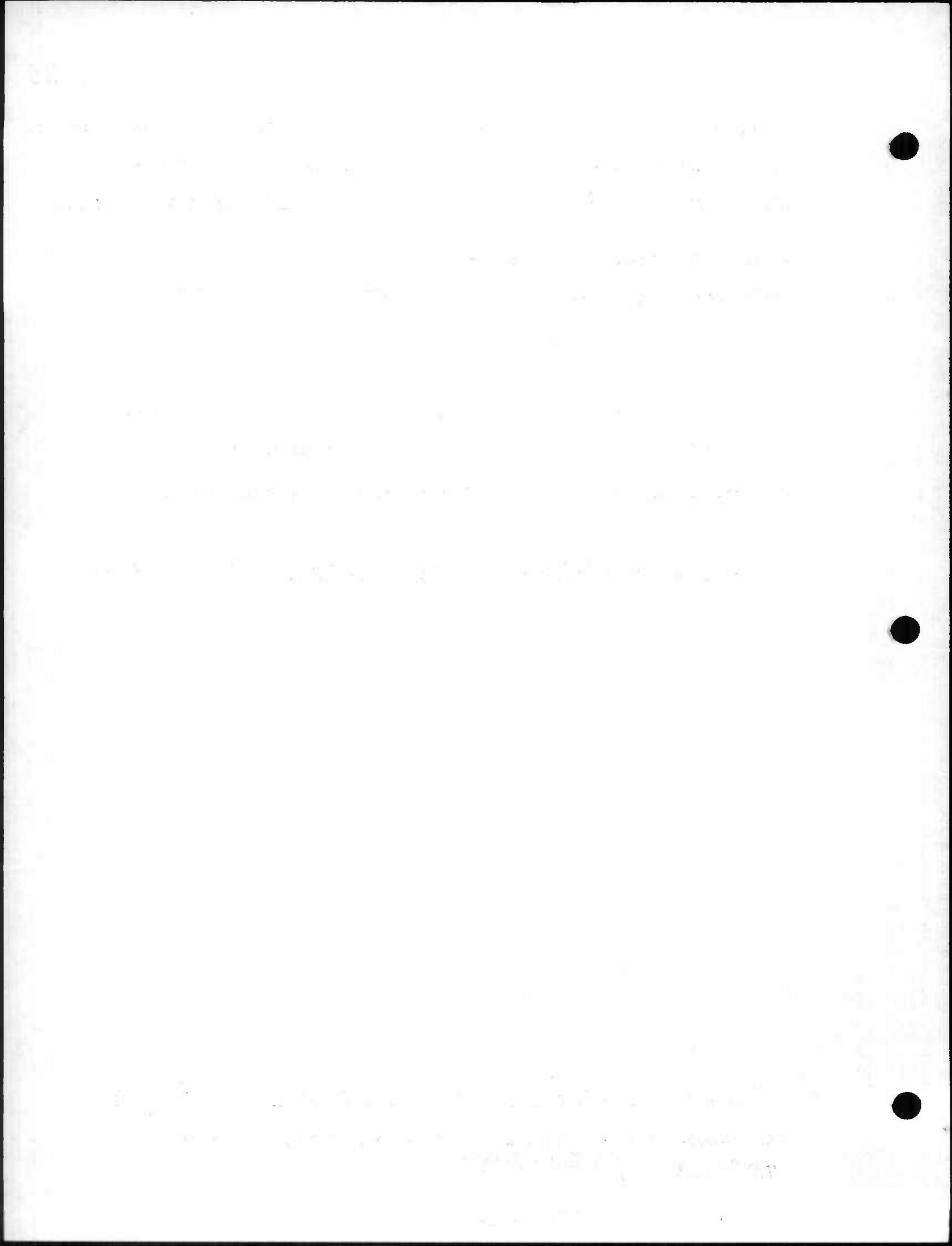
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14540

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James H. Hibler</b>				2. Date of Death Month <b>May</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>7:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview M.C.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>225-18-6083</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 21, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>N/A</b>	
Usual Residence of Decedent								
10a. State <b>Md</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>N/A</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>7312 Wenig Ave</b>			10f. Zip Code <b>21222</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>			16b. Kind of Business/Industry <b>Beth - Steel</b>			17. Father's Name (First, Middle, Last) <b>Harry Hibler</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Leanna Gentry</b>			19a. Informant's Name/Relationship (Type, Print) <b>Marguerite Hibler</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7312 Wenig Ave Baltimore, Md 21222</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge</b>			20c. Location - City or Town, State <b>5/21/96 Elkridge, Md</b>		
21. Signature of Funeral Service Licensee <b>Anthony Colt Connolly</b>			22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hypoxia</b>  Due to (or as a consequence of): <b>Squamous cell carcinoma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>1 month</b> <b>2 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>J. Bay H. Hon MD</b>								
29c. License number <b>96017</b>								
29d. Date signed (Month, Day, Year) <b>MAY 17, 1996</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hopkins - Bayview 4940 Eastern Ave Baltimore, Md 21224</b>								
31. Date of Death <b>MAY 20 1996</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14541

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerald Johnson Jr.</b>				2. Date of Death Month <b>May</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>9:39 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-03-2394</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN 14, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>							
Usual Residence of Decedent								
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>615 NORTH WASHINGTON STREET</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAN</b>			16b. Kind of Business/Industry <b>JANITORIAL</b>	
17. Father's Name (First, Middle, Last) <b>GERALD JOHNSON SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA TYLER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>PRISCILLA JOHNSON (SIS-IN-LAW)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 N. WASHINGTON ST. BALTO, MD 21205</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEM</b>		20c. Location - City or Town, State <b>5/15/96 LANSDOWNE, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTO, MD. 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): <b>sepsis</b>  Due to (or as a consequence of): <b>urinary tract infection</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 weeks</b> <b>3 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Q Hsu MD</b>		29c. License number <b>96017</b>		29d. Date signed (Month, Day, Year) <b>May 10, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jeff Hsu, MD 4940 Eastern Ave Baltimore, MD 21224</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

item #4,16b, filmg 736, 6/10/8, c/w

State of Maryland / Department of Health and Mental Hygiene

96 14542

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris A Jones</b>				2. Date of Death Month Day Year <b>May 16 1996</b>		3. Time of Death <b>22:55p</b>	
	4a. Facility Name (If not institution, give street and number) <b>MERCY HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-56-7064</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG 15, 1950</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>1526 NORTH MOUNT STREET</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COOK</b>		16b. Kind of Business/Industry <b>CATERER COUNTRY CLUB</b>		
17. Father's Name (First, Middle, Last) <b>JOSEPH PERKINS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MINNIE CRAIG</b>				
19a. Informant's Name/Relationship (Type, Print) <b>EVELYN J. JONES (DAUH)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>804 PEACH ORCHARD LANE BALTO, MD. 21222</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		Date <b>5/22/96</b>		20c. Location - City or Town, State <b>LANSDOWNE, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAPLE FUNERAL SERVICE 5502 WINNER AVE. BALTO, MD. 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. fungal septicemia</b> Due to (or as a consequence of): <b>b. acute myelogenous leukemia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>4 days</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>David Schneider MD</b>				29c. License number <b>P07767</b>		29d. Date signed (Month, Day, Year) <b>May 16, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David Ateschneider Dept of Medicine Univ of MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature <b>Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68780,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14543

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES M. JOHNSON

2. Date of Death

Month Day Year  
MAY 15, 1996

3. Time of Death

3:25 AM

4a. Facility Name (If not institution, give street and number)

VAMHCS--Fort Howard Division

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-22-1259

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 12 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2814 Auchentoroly Terrace

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 47/50

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

12th grade

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PLUMBER

16b. Kind of Business/Industry

PLUMBING

17. Father's Name (First, Middle, Last)

BURNARD JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED BRUMMELL

19a. Informant's Name/Relationship (Type, Print)

Octavia Lankford/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2814 Auchentoroly Terrace, Baltimore Maryland 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

5-20-96 OWINGS MILLS, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY ARREST DUE TO PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

3 MONTHS

c. HYPERTENSION

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-18298

29d. Date signed (Month, Day, Year)

MAY 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. AUGUSTIN CHYU, M.D. -- 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

State  
Registrar

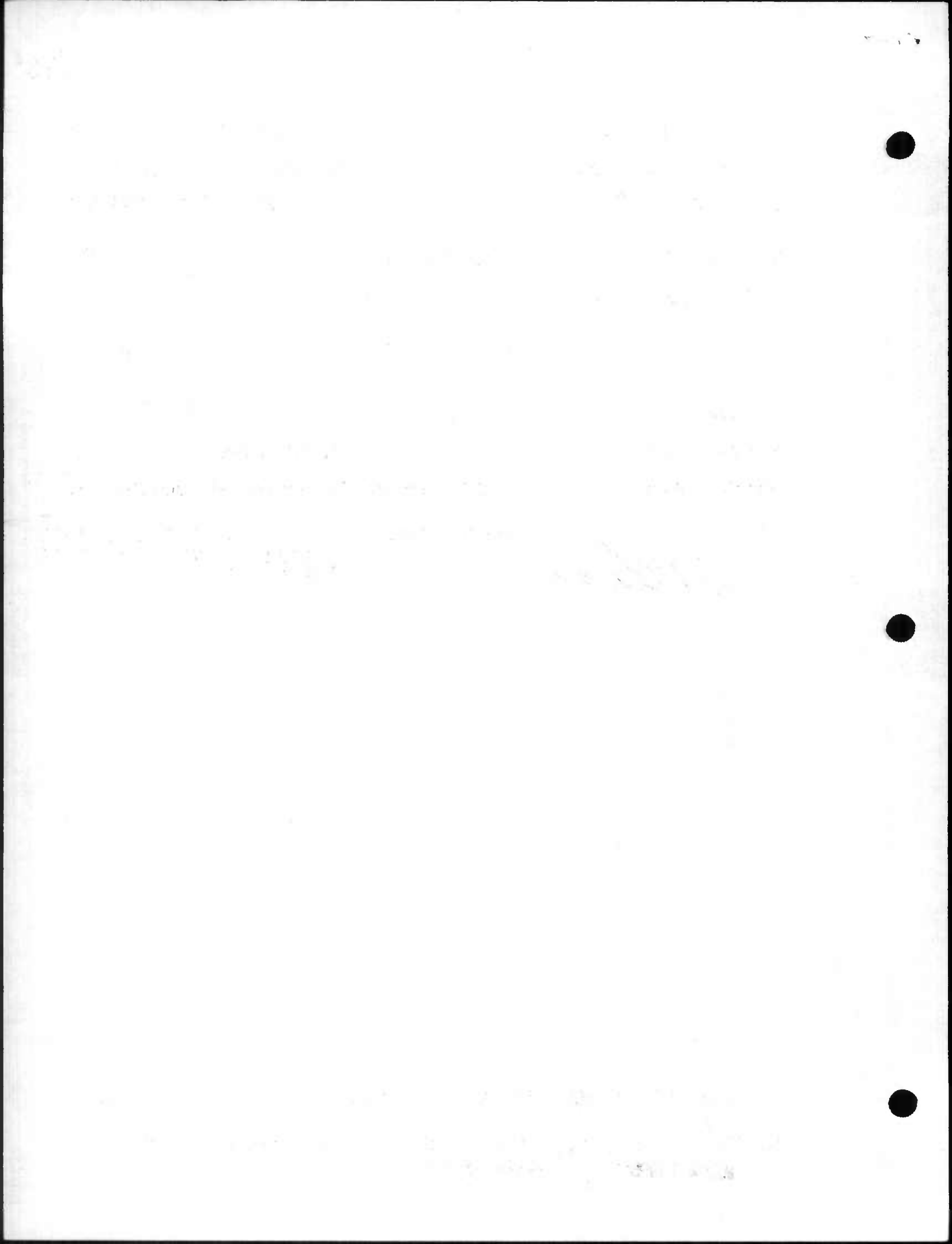
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



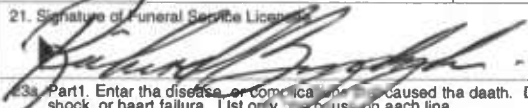
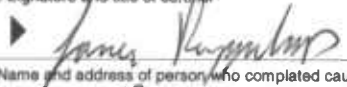

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14544

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian Kwiatkowski</b>				2. Date of Death Month <b>May</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>7:25 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Meridian Health Care At Spa Creek</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>216-05-0505</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 2, 1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Sherwood Forest</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>635 Maid Marion Hill</b>			10f. Zip Code <b>21405</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collega (1-4or 5+) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Baltimore Co. Schools</b>				
	17. Father's Name (First, Middle, Last) <b>Sam Schiff</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Kapul</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Hope Sibert (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>635 Maid Marion Hill Sherwood Forest, Md. 21405</b>				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		Data <b>5/15/1996</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>						
	23a. Part I. Enter the disease or condition which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Arrest</b> Due to (or as a consequence of): b. <b>Stroke</b> Due to (or as a consequence of): c. <b>Coronary artery disease</b> Due to (or as a consequence of): d. <b>Hypertension</b>								
	Approximate Interval Between Onset and Death a. <b>5 min</b> b. <b>1 month</b> c. <b>years</b> d. <b>years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D25499</b>		29d. Date signed (Month, Day, Year) <b>5/14/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Ruppel MD 180 Admiral Cochrane Dr Annapolis, MD 21401</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

10

1. The first part of the report is devoted to a general survey of the situation in the country. It is followed by a detailed analysis of the economic situation, which shows a steady decline in the standard of living of the population. The third part of the report is devoted to a study of the social situation, which shows a similar decline in the standard of living of the population.

2. The second part of the report is devoted to a study of the political situation. It shows a steady decline in the standard of living of the population, which is reflected in the political situation. The third part of the report is devoted to a study of the cultural situation, which shows a similar decline in the standard of living of the population.

3. The third part of the report is devoted to a study of the international situation. It shows a steady decline in the standard of living of the population, which is reflected in the international situation. The fourth part of the report is devoted to a study of the future of the country, which shows a similar decline in the standard of living of the population.

4. The fourth part of the report is devoted to a study of the future of the country. It shows a steady decline in the standard of living of the population, which is reflected in the future of the country. The fifth part of the report is devoted to a study of the future of the world, which shows a similar decline in the standard of living of the population.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14545

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MELVIN CHARLES KREISEL</b>				2. Date of Death Month <b>MAY</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>4:58 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>146 S. ELLWOOD AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>219-18-3178</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>5/14/1925</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Md.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>n/a</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>146 S. Ellwood Avenue</b>			10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates: <b>1942-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steelworker</b>			16b. Kind of Business/Industry <b>Armco</b>	
	17. Father's Name (First, Middle, Last) <b>Sylvester Kreisel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Matilda Hlavin</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>wife</b> <b>Marlene Kreisel</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>146 S. Ellwood Avenue Baltimore, Md. 21224</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>5/21/96 Baltimore, Md.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Baltimore, Md. 21224</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cancer of the lung</b> Due to (or as a consequence of):  <b>b. ...</b> Due to (or as a consequence of):  <b>c. ...</b> Due to (or as a consequence of):  <b>d. ...</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-17-96</b>		28b. Time of Injury <b>10:15 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot self</b>
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 18, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14546

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marian Bridget Kidd</b>				2. Date of Death Month Day Year <b>May 15, 1996</b>		3. Time of Death <b>6:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9 Highfield Court</b>				4b. City, Town, or Location of Death <b>COCKEYSVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-22-4375</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 21, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>IOWA</b>		10. Usual Residence of Decedent 10a. State <b>MARYLAND</b> 10b. County <b>BALTIMORE</b> 10c. City, Town or Location <b>COCKEYSVILLE</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
	16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>William Edward Kreul</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Alice O'Brien</b>		19. Informant's Name/Relationship (Type, Print) <b>William Francis Kidd</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Highfield Court Cockeysville, MD 21030</b>		20. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mausoleum</b>		20c. Location - City or Town, State <b>Timonium, MD 21093</b>	
	21. Signature of Funeral Service Licensee <i>Lowell M. Lemmon</i>		22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd. Timonium, MD 21093</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pancreatic cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Mark R. Stromberg</i>		29c. License number <b>032543</b>		29d. Date signed (Month, Day, Year) <b>5/16/96</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mark R. Stromberg, M.D. Suite 410 GBMC East Pavilion, Towson, MD 21204</b>				31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>			
	32. Registrar's Signature <i>John F. ...</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.




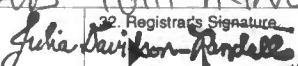
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14547

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry C. Koutalidis				2. Date of Death Month Day Year May 16 1996				3. Time of Death 5:20 P.M.								
	4a. Facility Name (If not institution, give street and number) Montgomery County General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery								
Funeral Director	5. Social Security Number 005-18-5084		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) May 22, 1923		9. Birthplace (State or Foreign Country) New Hampshire				
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Spencerville						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number 1910 Spencerville Road				10f. Zip Code 20868				10g. Citizen of What Country? United States								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor				16b. Kind of Business/Industry Landscaping								
	17. Father's Name (First, Middle, Last) Costas Koutalidis				18. Mother's Name (First, Middle, Maiden Surname) Despina Theodoridou												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharon V. Dustin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Quinn Road Frederick, Maryland 21701												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery				Date 5/25/96		20c. Location - City or Town, State Saco, Maine						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707												
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic non-HODGKIN'S LYMPHOMA</u> months Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death																
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D38457				29d. Date signed (Month, Day, Year) MAY 17, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. GOYAZ MD 1811 PRINCE PHILIP DR OLNEY MD 20832																	
31. Date filed (Month, Day, Year) MAY 20 1996				32. Registrar's Signature 													



96 14548

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Henry B. Kimmey</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>17</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>5:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-05-6362</b>		5. SEX <b>1 X M 2 F</b>	6. AGE (In yrs. last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 14, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>n/a</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>n/a</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>	
10e. STREET AND NUMBER <b>630 Piccadilly Road</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Military Officer &amp; Manager Employee Services</b>		17. KIND OF BUSINESS/INDUSTRY <b>Defense Balto. Gas &amp; Electric</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Kimmey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Buckingham</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Virginia O'Rourke Kimmey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>630 Piccadilly Road Towson, Maryland 21204</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Westminster Cemetery 5/21/96</b>		20c. LOCATION — City or Town, State <b>Westminster Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE OFFICER <i>Michael Dick</i>				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure, Coronary Artery Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sharon C. Jones MD</i>		29c. LICENSE NUMBER <b>4176435AJJ068</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 17, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SHARON C JONES, MD UNIT Bldg MD 21218 Dept of Internal Medicine</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14549

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MAE MATTHEWS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>16</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:55 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-22-2809</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 9, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1537 Homestead Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>			
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1537 Homestead Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>in private home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Fannie Wilkens</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nora Williams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1127 N. Fulton Avenue, Baltimore, MD 21217</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 5-21</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>D. Valencia Holland</b>				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>minutes</b> b. <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>1 month</b> c. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>2 months</b> d. <b>Arteriosclerotic Vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>5 yrs</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert C. Brown MD</b>				29c. LICENSE NUMBER <b>208900</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-16-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert C. Brown MD 838 N. Eutan St. Balto Md 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14550

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL F. MATTISON Sr.

2. Date of Death

MAY 16, 1996

3. Time of Death

4:52 PM

4a. Facility Name (If not Institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

217-14-7279

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 27, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3025 Ridge Rd.

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plasterer

16b. Kind of Business/Industry

Residential

17. Father's Name (First, Middle, Last)

Samuel R. Mattison

18. Mother's Name (First, Middle, Maiden Surname)

Marie Helmker

19a. Informant's Name/Relationship (Type, Print)

Pauline Mattison (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3025 Ridge Rd. Baltimore, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park

Date

5-21-96

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.  
8728 Liberty Rd. Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of MI S/P CABG

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D44505

29d. Date signed (Month, Day, Year)

May 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A.J. IMPERIA, Jr. - NWHC

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14551

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) ALICE MILLER 2. Date of Death Month 5 Day 15 Year 96 3. Time of Death 1:02 AM

4a. Facility Name (If not institution, give street and number) Mercy Medical Center 4b. City, Town, or Location of Death Balto 4c. County of Death N/A

5. Social Security Number 171-24-5040 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 66 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Sept 7, 1929 9. Birthplace (State or Foreign Country) md

Usual Residence of Decedent 10a. State md 10b. County N/A 10c. City, Town or Location Balto 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 16 Old Court Rd 10f. Zip Code 21208 10g. Citizen of What Country? U.S.A

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant 16b. Kind of Business/Industry Health Care Service

17. Father's Name (First, Middle, Last) Maurice onley 18. Mother's Name (First, Middle, Maiden Surname) Bessie Pea Co

19a. Informant's Name/Relationship (Type, Print) Beverly Ward-cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5304 Haddon Ave Balto, md 21207

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus mem. Date 5/21/96 20c. Location - City or Town, State Arbutus, md

21. Signature of Funeral Service Licensee Jerome A. Thompson 22. Name and Address of Facility March R.H. - west 4300 Wabash Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOGENIC SHOCK Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Thordmo 29c. License number P06829 29d. Date signed (Month, Day, Year) 5/15/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. LACKH, M.D. 301 St. Paul Place, Baltimore, MD

31. Date filed (Month, Day, Year) MAY 20 1996 32. Registrar's Signature John Davidson-Rendell

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14552

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dominick

MARZOLA

2. Date of Death

Month

Day

Year

13,

1996

3. Time of Death

10:45p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Medical Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore county

5. Social Security Number

216 32 7382

6. Sex

1 ☒ M2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 27, 1935

9. Birthplace (State or Foreign Country)

Balto. Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 N. Marlyn Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1959-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Dominick Marzola, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Perni

19a. Informant's Name/Relationship (Type, Print)

Marleen M. Marzola (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 N. Marlyn Ave. Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 5/17/1996

Data

20c. Location - City or Town, State

Baltimore Co., Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Eastern Ave. Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Recurrent ventricular fibrillation

Due to (or as a consequence of):

c. Chronic renal failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41360

29d. Date signed (Month, Day, Year)

5-13-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Stephen Noga 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12 + 1



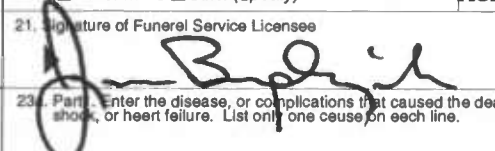
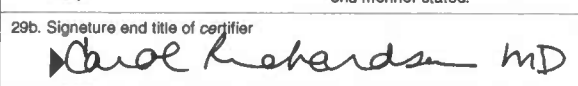
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14553

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice Virginia MOHR</b>				2. Date of Death Month Day Year <b>May 17, 1996</b>		3. Time of Death <b>2:40 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>214 20 4962</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 1, 1911</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		
Usual Residence of Decedent									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
10e. Street and Number <b>349 Townsend Road</b>									
10f. Zip Code <b>21221</b>									
10g. Citizen of What Country? <b>USA</b>									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>Housewife</b>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Daniel Huber</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Spangler</b>			19. Informant's Name/Relationship (Type, Print) <b>Andrew Mohr (son)</b>			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>58 Frog Hollow Lane Rising Sun, Maryland 21911</b>			20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Mem. Park</b>			
20c. Location - City or Town, State <b>Baltimore Co., Md.</b>			21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Bruzdinski Funeral Home PA</b> <b>1407 Eastern Ave Essex, Maryland 21221</b>			
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) e. <b>Upper gastrointestinal bleeding</b> Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatitis</b> <b>Coronary artery disease</b>									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)			28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier  <b>MD</b>			29c. License number <b>D46304</b>			29d. Date signed (Month, Day, Year) <b>May 17, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CAROL RICHARDSON MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MD 21237</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

J. Edgar



96 14554

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERWOOD Eugene MINNIX Sr.</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>17</b> YEAR <b>96</b>		3. TIME OF DEATH <b>10:50P.M.</b>													
4. SOCIAL SECURITY NUMBER <b>579 10 9370</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH Month, Day, Year <b>Nov. 8 1914</b>													
8. BIRTHPLACE (State or Foreign Country) <b>V.A.</b>																			
9a. FACILITY NAME (If not institution, give street and number) <b>Church Home Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto. City</b>		9c. COUNTY OF DEATH <b>Balto. City</b>													
10a. STATE <b>MD.</b>		10b. COUNTY <b>Balto. City</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
10e. STREET AND NUMBER <b>829 S Bond St.</b>				10f. ZIP CODE <b>21231</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retail Sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>															
17. FATHER'S NAME (First, Middle, Last) <b>Alex Minnix</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wiley Smithson</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Berwood E. Minnix Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 Main St. #2 Laurel MD 20707</b>															
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Metaco Crematory</b>		20c. LOCATION — City or Town, State <b>May 22 CATOWSVILLE MO.</b>															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Don P. Phutts</b>				22. NAME AND ADDRESS OF FACILITY <b>CHARITON F.H. 2007 EASTERN AVE. 21231</b>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular fibrillation</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Ventricular Tachycardia</b></td> </tr> <tr> <td>b.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Pulmonary edema.</b></td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> </table>								a.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Ventricular Tachycardia</b>	b.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Pulmonary edema.</b>	c.	DUE TO (OR AS A CONSEQUENCE OF):		d.	DUE TO (OR AS A CONSEQUENCE OF):	
a.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Ventricular Tachycardia</b>																	
b.	DUE TO (OR AS A CONSEQUENCE OF):	<b>Pulmonary edema.</b>																	
c.	DUE TO (OR AS A CONSEQUENCE OF):																		
d.	DUE TO (OR AS A CONSEQUENCE OF):																		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Suave hypertension</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)															
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D17005</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/17/96</b>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GOPAL GARUSWAMY MD. Church Hospital. PACT MD</b>																			
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>															

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14555

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>ROY MITCHELL</b>			2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>8</b> YEAR <b>1996</b>			3. TIME OF DEATH <b>3:35 p.m.</b>					
4. SOCIAL SECURITY NUMBER <b>220-94-9467</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 20, 1931</b>		8. BIRTHPLACE (State or Foreign Country) <b>Panama</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Laurel Regional Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Laurel</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>13420 Deerfield Road</b>				10f. ZIP CODE <b>20708</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Columbia, S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>unknown</b>			14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Security Guard</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Frafael Mitchell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mercedes Cordoba</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Rosa Mitchell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13420 Deerfield Road, Laurel, MD. 20708</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>removal</b>			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade</i> <b>Ronald S. Wade, Dir.</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201-1559</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACIDOSIS, RENAL TRANSPLANT RECIPIENT, HYPOXEMIA</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Berger MD</i>			29c. LICENSE NUMBER <b>025925</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 13, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>			32. REGISTRAR'S SIGNATURE <i>J. Berger</i>								

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14556

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARION M. McDONALD</b>				2. Date of Death Month <b>MAY</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>9:50 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>CITY</b>	
Funeral Director	5. Social Security Number <b>216-24-8228</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 15 1925</b>	
	9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1600 McKean Avenue</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th grade</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mason Tender</b>		16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Frederick McDonald</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>		19e. Informant's Name/Relationship (Type, Print) <b>Audrey McDonald/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1600 McKean Avenue Baltimore, Maryland 21217</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		20c. Location - City or Town, State <b>5-17-96 Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>		
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>MAY 20 1996</b>		
28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D19057</b>		
29d. Date signed (Month, Day, Year) <b>MAY 13 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>PELAYO E. CORREA MD LIBERTY MEDICAL CENTER</b>		31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out, the Funeral Director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14557

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude MacDonald				2. Date of Death Month Day Year May 15, 1996		3. Time of Death 1:10 A.M.	
	4e. Facility Name (If not institution, give street and number) 515 New York Avenue				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 291-82-1004		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) July 4, 1918	
	9. Birthplace (State or Foreign Country) Michigan		10. Usual Residence of Decedent 10a. State: MD 10b. County: Montgomery 10c. City, Town or Location: Takoma Park 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teller	
	17. Father's Name (First, Middle, Last) Edward Miller		18. Mother's Name (First, Middle, Maiden Surname) Agnes Allard		19a. Informant's Name/Relationship (Type, Print) Carole Crandon/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 New York Avenue, Takoma Park, Maryland 20912	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Cr. 5/16		20c. Location - City or Town, State Laurel, Maryland		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic obstructive pulmonary disease</i>				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D01732	
	29d. Date signed (Month, Day, Year) 5/15/96				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Robert Dietz 5711 Sarvis Avenue #100, Riverdale, Maryland 20737		31. Date filed (Month, Day, Year) MAY 20 1996	
	32. Registrar's Signature <i>[Signature]</i>				33. Registrar's Name Julia Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 14558

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Irene C. Meehan</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>16</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>927</b> M													
4. SOCIAL SECURITY NUMBER <b>216-05-8426</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 30, 1913</b>													
9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing Home-Frankford</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>													
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>													
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2916 E. Northern Pkwy.</b>															
10f. ZIP CODE <b>21214</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>															
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>															
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Bailor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Helinski</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Carole Ann Gale / daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6117 Lea Ray Drive Greensboro, N.C. 27410</b>															
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. LOCATION — City or Town, State <b>5/20/96 Baltimore, Maryland</b>		20d. DATE													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Brian A. Willem</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																			
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST																			
<table border="1"> <tr> <td>Due to (or as a consequence of):</td> <td>Sepsis</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td>Osteomyelitis</td> <td>1 WEEK</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td>Sacral Pressure Ulcer</td> <td>1 WEEK</td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td>Multi-Infarct Dementia</td> <td>YEARS</td> </tr> </table>								Due to (or as a consequence of):	Sepsis	Approximate Interval Between Onset and Death	Due to (or as a consequence of):	Osteomyelitis	1 WEEK	Due to (or as a consequence of):	Sacral Pressure Ulcer	1 WEEK	Due to (or as a consequence of):	Multi-Infarct Dementia	YEARS
Due to (or as a consequence of):	Sepsis	Approximate Interval Between Onset and Death																	
Due to (or as a consequence of):	Osteomyelitis	1 WEEK																	
Due to (or as a consequence of):	Sacral Pressure Ulcer	1 WEEK																	
Due to (or as a consequence of):	Multi-Infarct Dementia	YEARS																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED															
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Fredrick S. Glicks M.D.</b>				29c. LICENSE NUMBER <b>D22645</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/17/96</b>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FREDRICK SLICKS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</b>																			
31. DATE SIGNED (Month, Day, Year) <b>MAY 20 1996</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson</b>															

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 14559

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>COLUMBUS NEWBY Sr.</b>				2. Date of Death Month <b>May</b> Day <b>14</b> Year <b>96</b>		3. Time of Death <b>9:45pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Northwest Medical Center</b>				4b. City, Town, or Location of Death <b>N/A</b>		4c. County of Death <b>Balto</b>		
Funeral Director	5. Social Security Number <b>219-28-1330</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 6, 1934</b>	9. Birthplace (State or Foreign Country) <b>md</b>	
	Usual Residence of Decedent								
10a. State <b>md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Balto</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>4308 Elderon Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy machine operator</b>			16b. Kind of Business/Industry <b>AT+T</b>		
17. Father's Name (First, Middle, Last) <b>Dempsey Newby</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Navolia Anthony</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Newby - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4308 Elderon Ave Balto, md 21215</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge</b>		Data <b>5/20/96</b>		20c. Location - City or Town, State <b>Balto, md</b>		
21. Signature of Funeral Service/Licensee <b>Dola March</b>				22. Name and Address of Facility <b>Marh Alt-west 4300 Wabash Ave</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. END STAGE RENAL FAILURE</b> Due to (or as a consequence of): <b>b. METABOLIC ENCEPHALOPATHY</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>2 YEARS</b> <b>1 MONTH</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS.</b> <b>BILATERAL ABOVE KNEE AMPUTATION</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Joginder P Mehta m.o</b>		29c. License number <b>041410</b>		29d. Date signed (Month, Day, Year) <b>May 14th, 96.</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joginder P Mehta NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature <b>Don-Randall</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



96 14560

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>JESSICA NELSON</u>				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>10</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>3:22 AM</u>	
4. SOCIAL SECURITY NUMBER <u>216-78-3829</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>35</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 7, 1960</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Church Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>n/a</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>1503 Ensor Street</u>				10f. ZIP CODE <u>21202</u>		10g. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>unknown</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <u>unknown</u>		14. RACE — American Indian, Black, White, etc. Specify: <u>black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unknown</u> College (1-4 or 5+) <u>unknown</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>unknown</u>		16b. KIND OF BUSINESS/INDUSTRY <u>unknown</u>	
17. FATHER'S NAME (First, Middle, Last) <u>unknown</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>unknown</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>unknown</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <u>removal</u>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>in-state</u>		20c. LOCATION — City or Town, State <u>removal</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald S. Wade, Dir.</u>				22. NAME AND ADDRESS OF FACILITY <u>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201-1559</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ACQUIRED IMMUNE DEFICIENCY SYNDROME</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>DRUG ABUSE</u> b. <u>DRUG ABUSE</u> c. <u>DRUG ABUSE</u> d. <u>DRUG ABUSE</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>6 months</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PNEUMONIA</u> <u>RENAL FAILURE</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>R. Bokhari MD</u>				29c. LICENSE NUMBER <u>D-26594</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/10/1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>RIAZ BOKHARI MD 100 N. BROADWAY BALTIMORE MD 21231</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 20 1996</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodella</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
FEB 11 1961  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

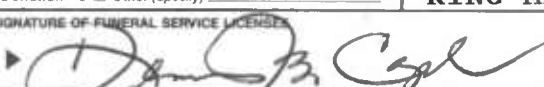
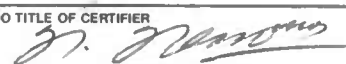
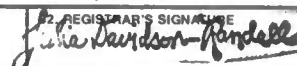
*[Signature]*

WILLIAM S. YAM

96 14561

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ADRIAN DEBORAH ORAM</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>17</b> YEAR <b>96</b>		3. TIME OF DEATH <b>11:43 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-44-2755</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC 19, 1943</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS AT MERCY</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1819 E. BIDDLE STREET</b>	
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) _____		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEKEEPER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOTEL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>RALPH TERRENTINE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EATHER MAE McARTHUR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JACQUELINE JOHNSON (SIS)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6409 LAURELTON AVENUE BALTIMORE, MD. 21214</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEM PARK 5/21/96</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTIMORE 21215</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COLON CANCER</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ b. _____ c. _____ d. _____						Approximate Interval Between Onset and Death <b>27 MONTHS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> <b>STELLA MARIS AT MERCY</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>040480</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 20, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FERNANDO J. FERRO, MD 5810 BELAIR RD BALTO., MD 21206</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b> REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 14562

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Stewart O'Hare, Sr.				2. DATE OF DEATH MONTH DAY YEAR May 17, 1996		3. TIME OF DEATH 1:45 A.M.	
4. SOCIAL SECURITY NUMBER 212-20-2786		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 05, 1925	
8. BIRTHPLACE (State or Foreign Country) Baltimore, Md.				9a. FACILITY NAME (If not institution, give street and number) 443 Range Road		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore Co.				10a. STATE Maryland		10b. COUNTY Baltimore Co.	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 443 Range Road	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 6/14/43-4/10/46				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physicist		16b. KIND OF BUSINESS/INDUSTRY Defense Contracts	
17. FATHER'S NAME (First, Middle, Last) James O'Hare				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Stewart			
19a. INFORMANT'S NAME (Type/Print) Jill (Nee Bateman) O'Hare (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 Range Road Towson, Maryland 21204			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 5/18/96		20c. LOCATION — City or Town, State Towson, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gair				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. COPD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - post thoracotomy for attempted ligation - SIRS - prostate CA - CAD p CABG							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William E. Randall, M.D. William E. Randall				29c. LICENSE NUMBER D 15808		29d. DATE SIGNED (Month, Day, Year) May 17, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1205 York Road Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAY 20 1996				32. REGISTRAR'S SIGNATURE William E. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM#1 film g735 5/20/96ag perFH Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DEVIN <del>KEYON</del> KEON PAYNE</b>					2. Date of Death Month <b>May</b> , Day <b>18</b> , Year <b>1996</b>		3. Time of Death <b>1:40PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>IN FRONT OF 2550 OSWEGO AVENUE</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
<b>Funeral Director</b>	5. Social Security Number <b>224-29-3957</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>13</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR 13, 1983</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	Usual Residence of Decedent									
<b>To Be Completed by Funeral Director</b>	10a. State <b>Maryland</b>		10b. County <b>4/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2555 Oswego Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4 or 5+) <b>Student</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>			16b. Kind of Business/Industry <b>GREENSPRING MIDDLE SCHOOL</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas Jackson</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>JANICE PAYNE</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>FLORENCE PAYNE, Grandmother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5525 OSWEGO AVE Baltimore, Maryland 21215</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		20c. Date <b>5-24-96</b>		20d. Location - City or Town, State <b>Baltimore, Md</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <b>CHARTMAN - HARRIS, H. 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>stab wound of chest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ON PORCH</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>5-18-96</b>		28b. Time of Injury <b>1338 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject stabbed</b>	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>porch</b>							
			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2550 Oswego Ave</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 19, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14564

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Verners K. PIRONIS</b>				2. Date of Death Month Day Year <b>May 16, 1996</b>		3. Time of Death <b>8:52 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>219-30-8514</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 18, 1912</b>	9. Birthplace (State or Foreign Country) <b>Latvia</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1516 National Drive</b>				10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>Latvia</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>		16b. Kind of Business/Industry <b>Meat Packing Co.</b>				
	17. Father's Name (First, Middle, Last) <b>Otokars Pironis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Alise L. Pironis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1516 National Dr. Baltimore, Md. 21237</b>				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		Data <b>5/20</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hartley Miller Funeral Home 7527 Harford Rd. Baltimore, Md. 21234</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary embolus</b> Due to (or as a consequence of): <b>b. Deep Vein thrombosis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>48 hours</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>left cerebrovascular accident with right hemiparesis, benign prostatic hypertrophy</b>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>H50391</b>		29d. Date signed (Month, Day, Year) <b>5/16/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Anthony Campbell 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be furnished for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14565

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary C. Pettit				2. Date of Death Month Day Year May 18 1996		3. Time of Death 7:15 AM		
	4a. Facility Name (If not Institution, give street and number) 5036 Castle Moore Drive				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard		
Funeral Director	5. Social Security Number 193-20-4274		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) June 13, 1927		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Howard		10c. City, Town or Location Columbia		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5036 Castlemoor Drive		10f. Zip Code 21042		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Agent		16b. Kind of Business/Industry Real Estate		17. Father's Name (First, Middle, Last) Stephen Connahey		
	18. Mother's Name (First, Middle, Maiden Surname) Grace A. Boyce		19a. Informant's Name/Relationship (Type, Print) John F. Pettit III		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Holly Parkway Williamstown, N.J. 08094		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State Williamstown, New Jersey		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue Catonsville, Maryland		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>PULMONARY EDEMA</u> Due to (or as a consequence of): b. <u>ACUTE BRONCHITIS</u> Due to (or as a consequence of): c. <u>RESPIRATORY DEPRESSION</u> Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 days 10 days 2 WKS		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings evaluable prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CONDROSARCOMA (L) LEG</u> <u>DIABETES MELLITUS</u> <u>SUPRA MORTAL OBESITY</u>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
State Registrar	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, tectory, offica building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
	29b. Signature and title of certifier 		29c. License number 038190		29d. Date signed (Month, Day, Year) 5/18/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MAURICE CURFEE MD 10308-B BALTO NATIONAL PIKE E.C 21092		
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature 		10					

Baltimore, Maryland 21215-0020

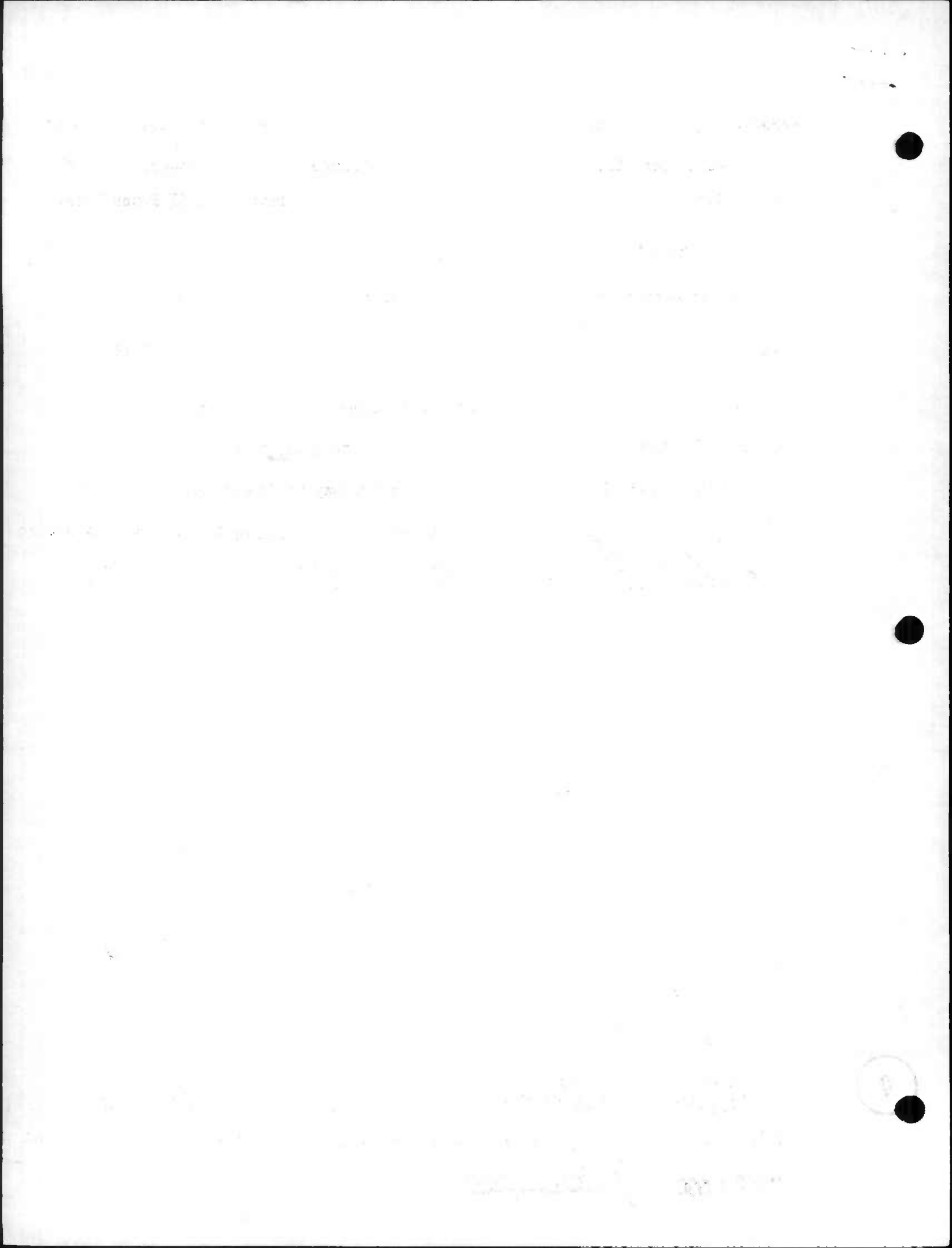
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the hospital or attending physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14566

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bertha M. Raber</i>				2. Date of Death Month <i>May</i> Day <i>17</i> Year <i>1996</i>		3. Time of Death <i>1:15 a.m.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Falston General hospital</i>				4b. City, Town, or Location of Death <i>Falston</i>		4c. County of Death <i>Harford</i>	
Funeral Director	5. Social Security Number <i>214 26 5625</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>94</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 5, 1901</i>	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Harford</i>		10c. City, Town or Location <i>Joppatown</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>305 Breslin Road</i>				10f. Zip Code <i>21085</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>James Redmond</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Keck</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Robert Raber (son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Marie Avenue Essex, Maryland 21221</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holly Hill Mem. Gardens</i>		20c. Location - City or Town, State <i>5/18/1996 Baltimore Co., Maryland</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Bruzdinski Funeral Home PA</i> <i>1407 Eastern Ave Essex, Maryland 21221</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>1. Congestive Heart Failure</i> Due to (or as a consequence of): <i>2. Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):  3. Due to (or as a consequence of):  4. Due to (or as a consequence of):								Approximate interval Between Onset and Death <i>3C</i> <i>30 yrs</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>H39022</i>		29d. Date signed (Month, Day, Year) <i>May 17 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>PETER LORESTE 1308 Business Center Way Edgewood MD</i>								
31. Date filed (Month, Day, Year) <i>MAY 20 1996</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14567

ITEM#26 film g735 5/20/96ag per HOSP

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dennis M Redmond

2. Date of Death

May 12 1996

Day

Year

3. Time of Death

0152 A.M.

4a. Facility Name (If not institution, give street and number)

North Arundel General Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Anne Arundel

5. Social Security Number

219-40-7433

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec 30, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

171 Mountain Rd

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Cup

17. Father's Name (First, Middle, Last)

Carl H. Redmond

18. Mother's Name (First, Middle, Maiden Sumama)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Robert Fleischmann/cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2022 Holborn Rd Baltimore, Md 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial 5/17/96

Data

20c. Location - City or Town, State

Glen Burnie, Md

21. Signature of Funeral Service Licensee

Anthony Colt Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk  
7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES

Due to (or as a consequence of):

c. NEUROPSYCH

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ POAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

025782

29d. Date signed (Month, Day, Year)

5/14/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEELE, C. ABB, MD GLEN BURNIE, MD 210

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

Julia Bruckner-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14568

ITEM#17 film g735 5/20/96ag perFH Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>PRESCILLA STOKES</b>				2. Date of Death Month <b>May</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>9:10 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS AT MERCY</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>219-76-2030</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b> Yrs. <b>36</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1959</b>	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>720 N. PORT STREET</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>United states</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>FRANCIS SCOTT KEY CTR.</b>	
17. Father's Name (First, Middle, Last) <b>JAMES JOHNSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH STOKES</b>			
19a. Informant's Name/Relationship (Type, Print) <b>SARAH BROADWATER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2405 E. MADISON STREET, BALTIMORE, MD 21205</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		Date <b>5-21</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee <i>H. Valencia Holland</i>				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of): <b>b. HIV Infection</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):							
Approximate Interval Between Onset and Death <b>UNKNOWN</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Dr. Johnson</i>				29c. License number <b>D40480</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO J. FERRO, MD</b>				<b>5810 BELAIR RD BALTO, MD 21206</b>			
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>				32. Registrar's Signature <i>Judi Anderson-Randall</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14569

ITEM#1 film g735 5/20/96ag perFH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY HOWARD</b>		2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>6:07 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-16-1881</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>July 9, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>3308 Hayward Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>8th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painting Contractor</b>	
16b. Kind of Business/Industry <b>Self-Employed</b>		17. Father's Name (First, Middle, Last) <b>Howard Walter</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Naomi Lookingbill</b>	
19a. Intendant's Name/Relationship (Type, Print) <b>Mrs. Anna Scott (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3308 Hayward Avenue Baltimore, MD 21215</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pipe Creek Cemetery</b>		20c. Location - City or Town, State <b>May 18 Uniontown, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Stephen M. Jenkins</i>		22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>CONTACT GUNSHOT WOUND OF HEAD</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CRUCIAL OF PROSTATE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <b>Partial</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>5-9-96</b>		28b. Time of Injury <b>1:36 P M</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SHOOT SELF</b>	
28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>3308 HAYWARD AVE BALTIMORE MD</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Mark A. Korow</i>		29c. License number <b>O.C.M.E.</b>	
29d. Data signed (Month, Day, Year) <b>MAY 15, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYANN A. KOROW 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature <i>John P. ...</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit






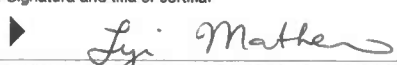

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14570

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Adolf SCHULTZ</b>				2. Date of Death Month <b>May</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>12:50pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-07-1589</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 11, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1404 Franklin Avenue</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Crane Operator</b>			16b. Kind of Business/Industry <b>Aero Space</b>	
17. Father's Name (First, Middle, Last) <b>Adam Schultz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Belkowski</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary V. Schultz (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1404 Franklin Ave. Essex, Md. 21221</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens Of Faith Cemetery</b>			Data <b>5/16/1996</b>		20c. Location - City or Town, State <b>Baltimore Co., Md.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Brudzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Ischemic bowel</b> Due to (or as a consequence of): b. <b>Triple Aortic Aneurysm</b> Due to (or as a consequence of): c. <b>Coronary Artery Disease</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>48 hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pandemic investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>#050164</b>		29d. Date signed (Month, Day, Year) <b>5/13/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Liji Mathew, M.D. 9000 Franklin Square Drive Baltimore, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14571

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie E. Smith</b>				2. Date of Death Month <b>May</b> Day <b>17</b> Year <b>1996</b>				3. Time of Death <b>1:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Edenwald Nursing Center</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-09-4028</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>800 Southerly Rd. Apt. 1301</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>Walter Hutchins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Blanche Simms</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Lewis E. Smith, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1013 Winsford Rd. Towson, Md. 21204</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chestnut Grove Presb. Cem.</b>		Date <b>5/21</b>		20c. Location - City or Town, State <b>Jacksonville, Md.</b>			
	21. Signature of Funeral Service Licensee <i>Gray D. Smith</i>				22. Name and Address of Facility <b>Hartley Miller Funeral Home 7527 Harford Rd. Baltimore, Md. 21234</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>congestive heart failure</b> Due to (or as a consequence of):</p> <p>b. <b>chronic bronchitis</b> Due to (or as a consequence of):</p> <p>c. <b>cerebrovascular insufficiency</b> Due to (or as a consequence of):</p> <p>d. <b>atherosclerotic disease</b></p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p><b>&lt; 1 yr.</b></p> <p><b>&lt; 1 yr.</b></p> <p><b>&lt; 1 yr.</b></p> <p><b>10 yrs.</b></p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Marcelino D. Alvarez</i> physician				29c. License number <b>D 29769</b>		29d. Date signed (Month, Day, Year) <b>5/20/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marcelino D. Alvarez 516 W. Rolling Rd. Baltimore.</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>		32. Registrar's Signature <i>John Anderson-Rodriguez</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14572

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **FRANCES ELIZABETH STANSBURY** 2. Date of Death **MAY 13 1996** 3. Time of Death **9:18 PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Fallston General Hospital** 4b. City, Town, or Location of Death **Fallston** 4c. County of Death **Harford**

5. Social Security Number **213-26-0502** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **66** Yrs. 8. Date of Birth (Month, Day, Year) **MAY 26, 1929** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Md.** 10b. County **Harford** 10c. City, Town or Location **Havre De Grace** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **709 Girard Street** 10f. Zip Code **21078** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) **11th** 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Medicine Aide** 17. Kind of Business/Industry **Hospital**

17. Father's Name (First, Middle, Last) **Charles Holly** 18. Mother's Name (First, Middle, Maiden Surname) **Martha Watters**

19a. Informant's Name/Relationship (Type, Print) **Connie Sconion (Daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **445 Chestnut St. Aberdeen, Md. 21001**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Harford Mem. Gardens** 20c. Location - City or Town, State **May 17, 1996 Aberdeen, Md.**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Beard Funeral Home 552 Lewis Street Havre De Grace, Md.**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **BACTERIAL SEPSIS** Due to (or as a consequence of): **4 DAYS** **INTERSTITIAL LUNG DISEASE** Due to (or as a consequence of): **RHEUMATOID ARTHRITIS** Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **INTERSTITIAL LUNG DISEASE** **RHEUMATOID ARTHRITIS** 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify) 27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how Injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D31775** 29d. Date signed (Month, Day, Year) **MAY 13, 1996**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **JOAN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047**

State  
Registrar

31. Date filed (Month, Day, Year) **MAY 20 1996** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14573

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mitchell Szypulski				2. DATE OF DEATH MONTH DAY YEAR May 18 1996		3. TIME OF DEATH 4 35 AM M	
4. SOCIAL SECURITY NUMBER 334-10-3405		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 15, 1917	
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Laurel	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8518 Briarcroft Lane	
10f. ZIP CODE 20708				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Automotive	
17. FATHER'S NAME (First, Middle, Last) Edward Szypulski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wanda Targowski			
19a. INFORMANT'S NAME (Type/Print) Wanda T. Gershowitz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8518 Briarcroft Lane, Laurel, Maryland 20708			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville MD Vets Cem. 5/22		20c. LOCATION — City or Town, State Crownsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edalle Dulegaly</i>				22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Hypertension, Aortic DUE TO (OR AS A CONSEQUENCE OF): Peripheral vascular disease DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Gattis</i>				29c. LICENSE NUMBER D-06644		29d. DATE SIGNED (Month, Day, Year) May 18, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE W. GATTIS 8037 LAUREL LAKES CT, LAUREL, MD 20707							
31. DATE FILED (Month, Day, Year) MAY 20 1996				32. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

461





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
ITEM#4c film g735 5/20/96ag perFH Certificate of Death

96 14574

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELSA LOUISE SHORES</b>			2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1996</b>			3. Time of Death <b>5:59am</b>					
	4a. Facility Name (If not institution, give street and number) <b>Pickersgill 615 Chestnut Avenue Towson MD 21204</b>			4b. City, Town, or Location of Death			4c. County of Death <b>BALTIMORE</b>					
Funeral Director	5. Social Security Number <b>217-54-4591</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. If Under 1 Year Months Days		8. If Under 24 Hrs. Hours Min.			
	9. Date of Birth (Month, Day, Year) <b>7-27-1898</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <b>615 Chestnut Ave.</b>			10f. Zip Code <b>21204</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Collage</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>					
	17. Father's Name (First, Middle, Last) <b>William P. George</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Maith</b>			19a. Informant's Name/Relationship (Type, Print) <b>Pickersgill Home</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 Chestnut Ave., Towson, Maryland 21204</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>			20c. Date <b>5-18-96</b>			20d. Location - City or Town, State <b>Pikesville, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Wallace S. Brooks, Jr.</b>			22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of): b. <b>Anemia</b> Due to (or as a consequence of): c. <b>Cardiac arrhythmias</b> Due to (or as a consequence of): d. <b>Congestive Heart Failure</b>			Approximate Interval Between Onset and Death <b>20 yrs</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Hypothyroidism</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and Title of certifier <b>Rita Pabla MD</b>			29c. License number <b>D47707</b>			29d. Date signed (Month, Day, Year) <b>5/16/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RITA PABLA MD 9 Schilling Road Hunt Valley MD 21031</b>			31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>			32. Registrar's Signature <b>John D. Henderson</b>						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5052.

Physician /Medical Examiner  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar  
DHMH 16 Rev 6/95



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EARLY STILL</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0220AM</b>	
4. SOCIAL SECURITY NUMBER <b>577-42-6522</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 11, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>D.C.</b>		10b. COUNTY <b>WASHINGTON</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE WASHINGTON</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4324 4TH ST, NW</b>				10f. ZIP CODE <b>20011</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12TH GRADE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOTEL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EARL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>STILL FRANCINA WATTS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALBERT CURRY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5810 PONTIAC AVE., COLLEGE PARK, MD. 20740</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. LOCATION — City or Town, State <b>5-15-96 BALTIMORE, MD.</b>		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO RESPIRATORY ARREST</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>LEUTROPHILIA</b> <b>ENDSTAGE RENAL DISEASE</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b> <b>SCHIZOPHRENIA</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Radcliffe M. Thomas</b>				29c. LICENSE NUMBER <b>04-2683</b>		29d. DATE SIGNED (Month, Day, Year) <b>05/11/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RADCLIFFE M. THOMAS 4000 W NORTHERN PARKWAY, BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Radcliff</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14576

ITEM #4b film g735 5/20/96 perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM JAMES TALLETT JR.</b>		2. Date of Death Month <b>MAY</b> Day <b>16</b> , Year <b>1996</b>		3. Time of Death <b>2237 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3107 CONOWINGO ROAD ROUTE#1</b>		4b. City, Town, or Location of Death <b>GIBSON</b>		4c. County of Death <b>HARFORD</b>		
Funeral Director	5. Social Security Number <b>478-82-2072</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>23</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 15, 1972</b>	9. Birthplace (State or Foreign Country) <b>Iowa</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Fallston</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2404 Watervale Road</b>			10f. Zip Code <b>21047</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4or 5+)</b> <b>2 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) <b>William James Tallett, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen Ann Zimmerer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. &amp; Mrs. Wm. Tallett, Sr. (Parents)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2404 Watervale Rd. Fallston, Md. 21047</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cem.</b>		Date <b>5/20/96</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Avenue Dundalk, Maryland 21222</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5/16/96</b>		28b. Time of Injury <b>2110 Hrs</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Date of Injury (Month, Day, Year) <b>5/16/96</b>		28b. Time of Injury <b>2110 Hrs</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject drove into lamp post</b>	
28a. Date of Injury (Month, Day, Year) <b>5/16/96</b>		28b. Time of Injury <b>2110 Hrs</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject drove into lamp post</b>	
28a. Date of Injury (Month, Day, Year) <b>5/16/96</b>		28b. Time of Injury <b>2110 Hrs</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject drove into lamp post</b>	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14577

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Louis R. Valentine</i>				2. Date of Death Month <i>MAY</i> Day <i>16</i> Year <i>1996</i>		3. Time of Death <i>8:53 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>SINA Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>		
Funeral Director	5. Social Security Number <i>219-28-4869</i>		6. Age (In yrs. last birthday) <i>63</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Apr. 10 1933</i>		9. Birthplace (State or Foreign Country) <i>S.C.</i>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>NA</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <i>5356 CUTHBERT AVE</i>			10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) <i>NA</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Truck Driver</i>		16b. Kind of Business/Industry <i>NARON CANDY CORP.</i>				
	17. Father's Name (First, Middle, Last) <i>C.T. VALENTINE</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>ESSIE JOHNSON</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>CHARLIE VALENTINE</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5356 CUTHBERT AVE. BALTO. MD. 21215</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>KING MEM. PARK</i>		20c. Date <i>5-21-96</i>		20d. Location - City or Town, State <i>RANDALLSTOWN, MD</i>		
	21. Signature of Funeral Service Licensee <i>Blayne B. Harris</i>			22. Name and Address of Facility <i>MARCH FUNERAL HOME - WEST 4300 WABASH AVE. BALTO MD 21215</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Myocardial Infarction</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Darryl Schick MD</i>		29c. License number <i>A52402321659944</i>		29d. Date signed (Month, Day, Year) <i>MAY 16 1996</i>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>DARYL SCHICK M.D. 2401 WEST BELVEDERE BALTIMORE MARYLAND 21215</i>									
31. Date filed (Month, Day, Year) <i>MAY 20 1996</i>		32. Registrar's Signature <i>Anderson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death. The Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14578

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH

WALKER

2. Date of Death

Month Day Year  
MAY 14, 1996

3. Time of Death

7:08 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-14-1189

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 26, 1914

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 N. Washington Street

10f. Zip Code

21231

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

various  
business

17. Father's Name (First, Middle, Last)

Dawson Armstead

18. Mother's Name (First, Middle, Maiden Surname)

India Forreist

19a. Informant's Name/Relationship (Type, Print)

Josie B. Little

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3013 Brighten Street, Baltimore, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Memorial Park

Date

5-20-96

20c. Location - City or Town, State

Arbutus, MD

21. Signature of Funeral Service Licensee

*S. Valencia Holland*

22. Name and Address of Facility

March Funeral Home

1101 E. North Avenue, Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Margarita Korell M.D.*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 20 1996

32. Registrar's Signature

*Margarita Korell*

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14579

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eva Ward				2. Date of Death Month Day Year May 15 1996		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) 9102 Bengal Road				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-01-2241		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 4, 1916	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Randallstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9102 Bengal Road				10f. Zip Code 21133		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George Phoebus				18. Mother's Name (First, Middle, Maiden Summa) Mamie Hickman			
	19a. Informant's Name/Relationship (Type, Print) Mr. Robert Ward Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9102 Bengal Road Randallstown, MD 21133			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State Sykesville, MD		20d. Date 5/17/96	
	21. Signature of Funeral Service Licensee James B. Grey				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF OVARY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier [Signature] MD				29c. License number 035606		29d. Date signed (Month, Day, Year) 5/15/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SAMUEL ZIGLER 21 CROSSROADS DR. #415 OWINGS MILLS, MD. 21117							
	31. Date filed (Month, Day, Year) MAY 20 1996							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14580

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Thelma Sirrenna WOLFE				2. Date of Death Month Day Year May 18, 1996		3. Time of Death 1:05 PM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228 18 3778		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01 20 07	9. Birthplace (State or Foreign Country) W. Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County N/A	10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4 North Glover Street				10f. Zip Code 21224		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housework		16b. Kind of Business/Industry At Home			
	17. Father's Name (First, Middle, Last) Thomas Willis				18. Mother's Name (First, Middle, Maiden Surname) Mamie Compton			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Juanita Baugher, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Fuselage Ave. Balto., Md. 21220			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Data 5-21-96	20c. Location - City or Town, State Overlea, Md.		
	21. Signature of Funeral Service Licensee Charles S. Zeiler				22. Name and Address of Facility Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Probable aspiration pneumonia Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 hrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Congestive heart failure ② Severe COPD. ③ Anemia ④ Dementia with agitation episodes							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M. Basile MD.		29c. License number D-38754		29d. Date signed (Month, Day, Year) 5-20-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASEEM. 100 N. BROADWAY, BALTIMORE, MD - 21231							
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature Julia Robinson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14581

ITEM#1 film g735 5/20/96ag perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROLAND OWEN WASHINGTON JR.				2. Date of Death MAY 05 1996		3. Time of Death 10:49 AM		
	4a. Facility Name (If not institution, give street and number) IN ALLEY NEXT TO 607 CATOR AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-70-0863		6. Sex M	7. Age (In yrs. last birthday) 37	8. Date of Birth MAY 22, 1958		9. Birthplace (State or Foreign Country) FLORIDA		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits Yes		
	10e. Street and Number 1522 Pentwood Road				10f. Zip Code 21239		10g. Citizen of What Country? USA		
	11. Marital Status Never Married		12. Was Decedent Ever in U.S. Armed Forces? No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) No		14. Race - American Indian, Black, White, etc. Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry Fresh Dough Pizza Delivery				
	17. Father's Name (First, Middle, Last) ROLAND O. WASHINGTON, SR.				18. Mother's Name (First, Middle, Maiden Surname) BERTHA L. ANDERSON				
	19a. Informant's Name/Relationship (Type, Print) BERTHA WASHINGTON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Pentwood Road Baltimore, Md 21239				
	20a. Method of Disposition Burial		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State BALTIMORE, Md		20d. Date 5/14/96		
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility CHATHAM - HARRIS H. 5440 REISTER TOWN ROAD BALTIMORE, Maryland 21215				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Blunt Force Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
24e. Was an autopsy performed? 1 Yes 2 No									
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
25. Was case referred to medical examiner? XX Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ALLEY							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) 5-5-96		28b. Time of Injury 1010 M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred Subject Beaten	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ALLEY		28f. Location (Street and Number or Rural Route Number, City or Town, State) 607 Cator Ave							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 05, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature John Andrew Randall							

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14582

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Laughton F. Weber				2. Date of Death Month Day Year May 16, 1996		3. Time of Death 6:30 AM	
	4a. Facility Name (If not institution, give street and number) Ivy Hall Geriatric Center				4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-07-2717		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 2-14-12	
	9. Birthplace (State or Foreign Country) MD		10. Usual Residence of Decedent 10a. State MD		10b. County Baltimore		10c. City, Town or Location Rosedale	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7925 Elmhurst Ave.		10f. Zip Code 21237		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Martin Marietta			
	17. Father's Name (First, Middle, Last) Frederick H. Weber				18. Mother's Name (First, Middle, Maiden Surname) Nettie A. Laughton			
	19a. Informant's Name/Relationship (Type, Print) Cathy Palley / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Burbage Ct. Baltimore, MD 21236			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee Dennis S. Kelly				22. Name and Address of Facility Cyach/Rosedale Funeral Home 1211 Chesaco Ave. Baltimore, MD 21237			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death ~ 5 years							
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> <u>RECURRENT ASPIRATION WITH CHRONIC PLEURAL EFFUSION</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier R. H. Newman, Jr.				29c. License number 015022		29d. Date signed (Month, Day, Year) 5/17/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8552 PHILADELPHIA RD., BALTIMORE, MD 21237								
State Registrar	31. Date filed (Month, Day, Year) MAY 20 1996				32. Registrar's Signature Julia Davidson-Rodale			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

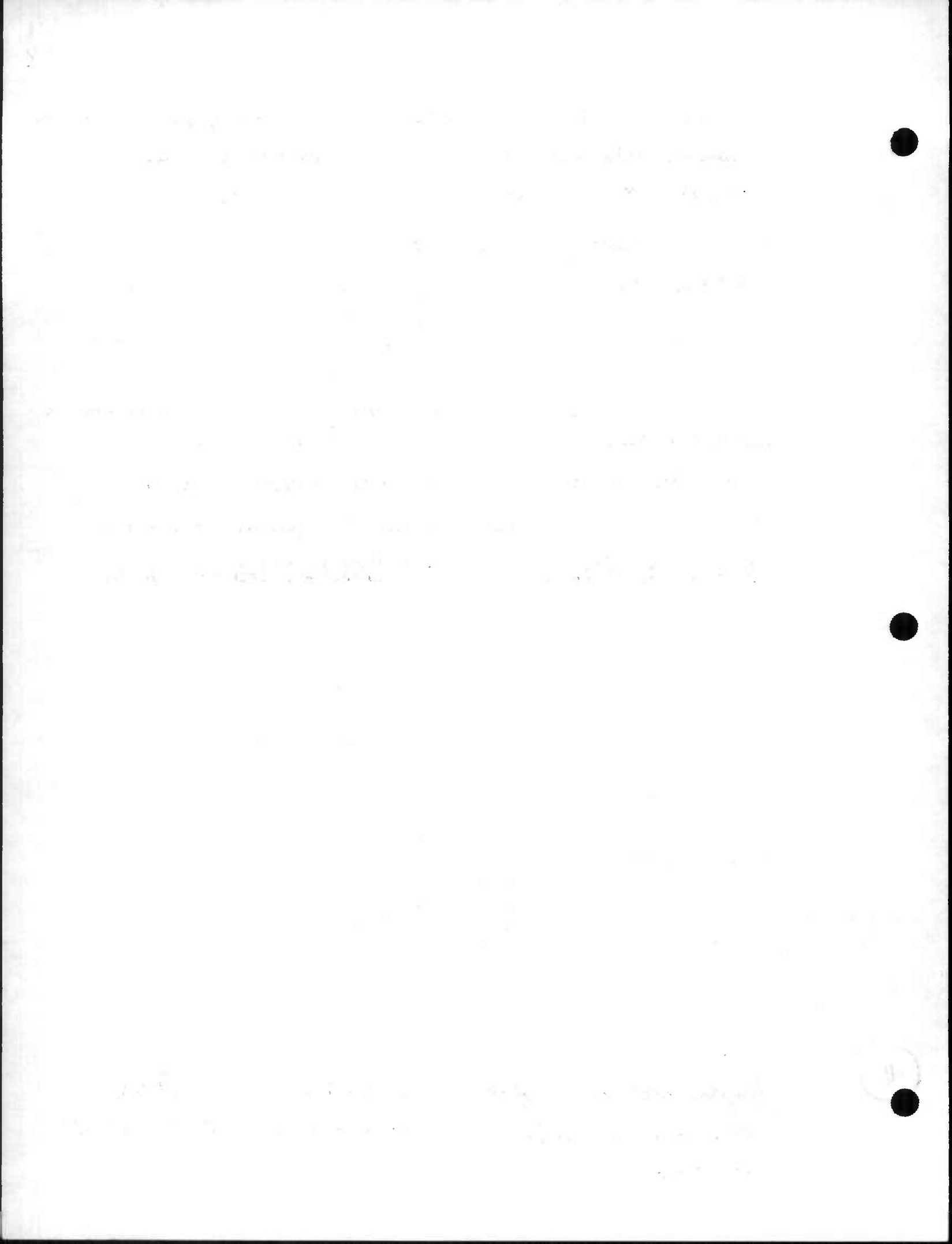
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14583

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Julia Wasko</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>16</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>11:10 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215125 054</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6/15/14</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Johns Hopkins Geriatric Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore City</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1801 Green Castle</i>				10f. ZIP CODE <i>21237</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Office Worker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Martin Marietta</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Pak</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Julia (unk.)</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Carl P. Wasko Sr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1801 Green Castle, Baltimore, MD 21237</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gardens of Faith 5-20-96</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Kelly</i>				22. NAME AND ADDRESS OF FACILITY <i>Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Baltimore, MD 21237</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute MI</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Amyotrophic lateral sclerosis</i>							Approximate Interval Between Onset and Death <i>minutes</i> <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>UGI bleed, anemia, MRSA colonized vent. dependent, dementia</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D28461</i>		29d. DATE SIGNED (Month, Day, Year) <i>5-16-96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard Bennett 5505 Hopkins Bayview Balto MD 21224</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 20 1996</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodarte</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14584

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William A. Wilson, Jr.						2. Date of Death Month Day Year May 16, 1996		3. Time of Death 5:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Annapolis Nursing & Rehabilitation Center						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 577-52-9443		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) April 7, 1937		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1526 Lodge Pole Court				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 3				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales			16b. Kind of Business/Industry Auto		
	17. Father's Name (First, Middle, Last) William A. Wilson, Sr.						18. Mother's Name (First, Middle, Maiden Summa) Mary Tracey			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret Anne Wilson/ Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Lodge Pole Court, Annapolis, Maryland 21401			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Data 5/21		20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Metastatic Renal Cell Cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D05192		29d. Date signed (Month, Day, Year) 5/17/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard I. Hochman, MD 1833 A Forest Dr, Annapolis, Md. 21401										
31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14585

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH Barbara WASCHEK</b>				2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>4:30 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-32-2864</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-15-1930</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street end Number <b>200 Towsontown Court, Apt. 311</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>U. S. A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College (1-4or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Assistant</b>		16b. Kind of Business/Industry <b>St. Joseph Med. Center</b>				
17. Father's Name (First, Middle, Last) <b>August Ruppert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Baier</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Eberhard J. Waschek (Husband)</b>				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Towsontown Court, Apt 311, Towson, Md. 21204</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gards.</b>		20c. Location - City or Town, State <b>5-20-96 Timonium, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Wallace S. Brooks, Jr.</b>				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. METASTATIC CANCER, UNKNOWN PRIMARY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street end Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Kendall Faulkner</b>				29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>5/17/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1996</b>								

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.

3. The third part is a description of the results of the study.

4. The fourth part is a discussion of the results and their implications.  
5. The fifth part is a conclusion and a list of references.

6. The sixth part is a list of references.  
7. The seventh part is a list of references.

8. The eighth part is a list of references.  
9. The ninth part is a list of references.

10. The tenth part is a list of references.

11. The eleventh part is a list of references.  
12. The twelfth part is a list of references.

13. The thirteenth part is a list of references.  
14. The fourteenth part is a list of references.  
15. The fifteenth part is a list of references.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14586

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Norma J. Azlein</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>1:34 AM</b>	
	4a. Facility Name (if not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>358-10-0876</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 17, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>Chicago, Ill.</b>		10a. State <b>N/A</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Washington, D.C.</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4414 16th Street, N.E.</b>		10f. Zip Code <b>20017</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> Collega (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registrar</b>		16b. Kind of Business/Industry <b>Education</b>				
17. Father's Name (First, Middle, Last) <b>William H. Eppens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel C. Caldwell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Arthur A. Azlein</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4414 16th Street, N.E., Washington, D.C. 20017</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>4/29/96 Alexandria, Virginia</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pleural effusion, Atrial fibrillation</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 42518</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Gue CHAZIAN, 1119 Rockwood Drive #316, Rockwood MD 20852</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14587

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Hale Andrew

2. Date of Death

Month Day Year  
April 26, 1996

3. Time of Death

8:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

25000 Woodfield Road

4b. City, Town, or Location of Death

Damascus

4c. County of Death

Montgomery

5. Social Security Number

009-03-9351

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 4, 1912

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7203 Radnor Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Research Clerk

16b. Kind of Business/Industry

U. S. Dept. of State

17. Father's Name (First, Middle, Last)

Arthur Hale

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice Lincoln

19a. Informant's Name/Relationship (Type, Print)

Merle M. Andrew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Swasey Burial Ground

Date

5-1-96

20c. Location - City or Town, State

New  
Meredith, Hampshire

21. Signature of Funeral Service Licensee

Elmer H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Group Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James Michael Anchors M.D.

29c. License number

D 29730

29d. Date signed (Month, Day, Year)

April 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#210

James Michael Anchors, M. D., 16220 Frederick Road, Gaithersburg, MD 20877

31. Date filed (Month, Day, Year)

APR 30 1996

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14588

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>James Anspach</b>				2. Date of Death Month <b>4</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>10:15 a.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Carriage Hill Nursing Home</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>578-58-2693</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-22-1911</b>	
9. Birthplace (State or Foreign Country) <b>U.S.A.</b>		10a. State <b>Washington, D.C.</b>		10b. County		10c. City, Town or Location <b>Washington, D.C.</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4449 Faraday Place N.W.</b>		10f. Zip Code <b>20016</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cartographer</b>		18b. Kind of Business/Industry <b>Mapping</b>			
17. Father's Name (First, Middle, Last) <b>Frederick Rea Anspach</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Effie Tannehill</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Frances A. Harrison-daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 6, Box 20 Concord Heights, Claremore, OK 74017</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Comfort Crematory</b>		Date <b>4/24/96</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>5130 Wisconsin Avenue, N.W. Joseph Gawler's Sons, Inc., Washington, D.C. 20016</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>5 mins.</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fractured Left Hip</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>3/24/96</b>		28b. Time of Injury <b>7:47 p.m.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred <b>Fell</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4449 Faraday Pl., N.W.</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D08546</b>		29d. Date signed (Month, Day, Year) <b>April 25, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John F. Tauber, M.D., 8218 Wisconsin Avenue, N.W. Ste. 318, Bethesda, MD 20814</b>							
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14589

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BABY GIRL

2. Date of Death

Month Day Year  
APRIL 26, 1996

3. Time of Death

10:10 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

5. Social Security Number

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4/25/96

9. Birthplace (State or Foreign Country)

Baltimore MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4327 Honine Road

10f. Zip Code

21755

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Steven Douglas Brown

18. Mother's Name (First, Middle, Maiden Surname)

Lisa Marie Alger

19a. Informant's Name/Relationship (Type, Print)

Lisa M. Alger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4327 Honine Rd. Jefferson MD 21755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark's Cemetery

Date

4/30

20c. Location - City or Town, State

Petersville MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home

100 Petersville Rd Brunswick MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congenital Diaphragmatic Hernia

Approximate Interval Between Onset and Death

1 day

Due to (or as a consequence of):

b. Prematurity

1 day

Due to (or as a consequence of):

c. Hypoxia

1 day

Due to (or as a consequence of):

d. Metabolic acidosis

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Elizabeth Cuervo Nelson

29c. License number

D30658

29d. Date signed (Month, Day, Year)

April 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Elizabeth Cuervo Nelson Tower 1 Johns Hopkins Hospital 600 N. Wolfe St Baltimore, MD 21205

31. Date filed (Month, Day, Year)

MAY 01 1996

32. Registrar's Signature

John A. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14590

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES THOMAS ANDERSON</b>			2. Date of Death Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>2245</b>																									
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>																									
Funeral Director	5. Social Security Number <b>578-10-2352</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9-19-14</b>																								
	9. Birthplace (State or Foreign Country) <b>D.C.</b>																														
Usual Residence of Decedent																															
10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BERLIN</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																									
10e. Street and Number <b>9 MORNING MIST DR.</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>																									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SOIL CONSERV. SPEC.</b>		16b. Kind of Business/Industry <b>USDA</b>																									
17. Father's Name (First, Middle, Last) <b>CHARLES T. ANDERSON</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>ANETTIA MOORE</b>																											
19a. Informant's Name/Relationship (Type, Print) <b>KAREN A. CRAMER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9032 OCEAN PINES BERLIN, MD., 21811</b>																											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		Data <b>4-30</b>		20c. Location - City or Town, State <b>SALISBURY, MD.</b>																									
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>																											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																															
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Chronic Aspiration Pneumonia</b></td> <td><b>2 weeks</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Cerebral Vascular Accident</b></td> <td><b>2 months</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td><b>Diabetes Mellitus</b></td> <td><b>un known</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>Chronic Aspiration Pneumonia</b>	<b>2 weeks</b>	Due to (or as a consequence of):			b.	<b>Cerebral Vascular Accident</b>	<b>2 months</b>	Due to (or as a consequence of):			Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	<b>Diabetes Mellitus</b>	<b>un known</b>	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Chronic Aspiration Pneumonia</b>	<b>2 weeks</b>																												
	Due to (or as a consequence of):																														
	b.	<b>Cerebral Vascular Accident</b>	<b>2 months</b>																												
	Due to (or as a consequence of):																														
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	<b>Diabetes Mellitus</b>	<b>un known</b>																												
	Due to (or as a consequence of):																														
d.																															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																									
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																									
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																											
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																															
29b. Signature and title of certifier 				29c. License number <b>BM 431 4465</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>																									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia Mahoney MD Atlantic General Hospital</b>																															
31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>				32. Registrar's Signature 																											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

State  
Registrar



5/8/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #1, per FD, Carroll County, WJL

Certificate of Death

Reg. No.

96 14591

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <i>ANNA A. ANGELL</i>		2. Date of Death Month <i>5</i> Day <i>7</i> Year <i>96</i>		3. Time of Death <i>7:20 AM</i>
4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>

Funeral  
Director

5. Social Security Number <b>215-18-2238</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 30 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent							
10a. State <b>MD</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>200 St. Luke Circle</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>teacher</b>		16b. Kind of Business/Industry <b>public schools</b>	
17. Father's Name (First, Middle, Last) <b>Charles Joseph Hull Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Engler</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Judith A. Angell, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>452 Uniontown Rd., Westminster, MD 21158-4218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Branch Cemetery</b>		20c. Location - City or Town, State <b>Westminster, MD</b>		20d. Date <b>05/09/96</b>	
21. Signature of Funeral Service Licensee <i>Kathleen Pites-Switzer</i>				22. Name and Address of Facility <b>Pites Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>			

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>4-14-96</b>
		b. <b>EMPHYSEMA</b> Due to (or as a consequence of):	<b>4-14-96</b>
		c. <b>PNEUMONIA</b> Due to (or as a consequence of):	<b>4-14-96</b>
		d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*CVA*  
*HWD*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*MARION J. SEVILLA P.O. BOX 571 WESTMINSTER, MD.*

31. Date filed (Month, Day, Year)

**MAY 08 1996**

32. Registrar's Signature

*John Andrew Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14592

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JULIA CHRISTINE BOWERSOX</b>				2. Date of Death Month Day Year <b>April 28, 1996</b>				3. Time of Death <b>1147</b>	
	4a. Facility Name (If not institution, give street and number) <b>Rt. 97 @ Pleasant Valley Road</b>				4b. City, Town, or Location of Death <b>Westminster</b>				4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>213-45-6620</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>9</b> Months <b>12</b>		8. Date of Birth (Month, Day, Year) <b>July 16, 1995</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>440 Dotsie Drive</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-0-</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>Paul Frederick Bowersox</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Irene Oja</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Paul F. Bowersox</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>440 Dotsie Drive, Westminster, MD 21157</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's U.C.C. Cemetery</b>		Data <b>5/1</b>		20c. Location - City or Town, State <b>Westminster, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Sue Ann Flaherty Myers</i>				22. Name and Address of Facility <b>Myers Funeral Home, 91 Willis Street, Westminster MD 21157</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE TRAUMA</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death <b>INSTANT</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MOTOR VEHICLE DEATH</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>APR. 28, 96</b>		28b. Time of Injury <b>1133 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>MVA</b>		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>RT 97 @ PLEASANT VALLEY RD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT. 97 @ PLEASANT VALLEY</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Philip N. Phelps, M.D., MECC</b>		29c. License number <b>D36908</b>		29d. Date signed (Month, Day, Year) <b>APR. 30, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11722 REISTERSTOWN RD., REISTERSTOWN, MD. 21136</b>		31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature <i>Jodi Newkirk-Rodall</i>						

Baby

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the financial aspects of the organization. It provides a detailed overview of the budget, including the projected income and expenses for the upcoming year. This section also discusses the various financial risks and how they are being managed to ensure the organization's financial stability.

3. The third part of the document addresses the operational aspects of the organization. It describes the various processes and procedures that are in place to ensure the efficient and effective delivery of services. This section also discusses the various challenges that the organization is facing and how they are being addressed.

4. The fourth part of the document discusses the human resources of the organization. It provides a detailed overview of the current staff, including their qualifications and experience. This section also discusses the various recruitment and retention strategies that are being used to ensure that the organization has the right people in the right places.

5. The fifth part of the document discusses the legal and regulatory aspects of the organization. It provides a detailed overview of the various laws and regulations that the organization is subject to, and how they are being managed to ensure compliance. This section also discusses the various legal risks and how they are being managed.

6. The sixth part of the document discusses the environmental aspects of the organization. It provides a detailed overview of the various environmental issues that the organization is facing, and how they are being managed to ensure that the organization is operating in a sustainable and responsible manner.

7. The seventh part of the document discusses the social aspects of the organization. It provides a detailed overview of the various social issues that the organization is facing, and how they are being managed to ensure that the organization is operating in a socially responsible manner.

8. The eighth part of the document discusses the overall performance of the organization. It provides a detailed overview of the various performance indicators that are being used to measure the organization's success, and how they are being managed to ensure that the organization is achieving its goals.

9. The ninth part of the document discusses the future of the organization. It provides a detailed overview of the various strategic initiatives that are being implemented to ensure the organization's long-term success, and how they are being managed to ensure that the organization is staying on track.

10. The tenth part of the document discusses the conclusion of the document. It provides a detailed overview of the various key findings and recommendations that have been identified, and how they are being managed to ensure that the organization is operating in a more effective and efficient manner.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14593

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WELDON LEONARD BOWERS, JR.						2. Date of Death Month Day Year APRIL 28, 1996		3. Time of Death 2130PM		
	4a. Facility Name (If not institution, give street and number) ROUTE 30 AND MICHELLE ROAD						4b. City, Town, or Location of Death MANCHESTER		4c. County of Death CARROLL COUNTY		
Funeral Director	5. Social Security Number 219-36-0546		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 7/12/1938		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10e. State MD.		10b. County CARROLL		10c. City, Town or Location MANCHESTER				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 3242 LINEBORO RD.				10f. Zip Code 21102		10g. Citizen of What Country? USA.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1962 1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRACK INSPECTOR			16b. Kind of Business/Industry RAILROAD				
17. Father's Name (First, Middle, Last) WELDON L. BOWERS, SR.						18. Mother's Name (First, Middle, Maiden Surname) RUTH JOSEPHINE GROFT					
19a. Informant's Name/Relationship (Type, Print) KEVIN B. BOWERS -SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 CHRIS LANE, WESTMINSTER, MD. 21158					
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN MEM. GARDENS		20c. Location - City or Town, State 5/2/96 FINKSBURG, MD.					
21. Signature of Funeral Service Licensee <i>Nancy S. Fletcher</i>				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 4-28-96		28b. Time of Injury 21:26 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver - auto - auto collision RT 30.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 29, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAY 01 1996		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





## State of Maryland / Department of Health and Mental Hygiene

Amended item #'s 23a &amp; 27 per OCME 5/13/96

Carroll County P.L.C.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GREGG CHARLES BURNS</b>				2. Date of Death Month Day Year <b>MAY 06, 1996</b>		3. Time of Death <b>13:43 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>E.B. ON BAUGHER RD.</b>				4b. City, Town, or Location of Death <b>near Lewistown</b>		4c. County of Death <b>FREDERICK</b>	
Funeral Director	5. Social Security Number <b>203-09-6846</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 1, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Thurmont</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12029 Baugher Rd.</b>		10f. Zip Code <b>21788</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>W W II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>civil engineer</b>		16b. Kind of Business/Industry <b>steel</b>			
	17. Father's Name (First, Middle, Last) <b>Timothy Burns</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Elizabeth Reynolds</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Marie L. Burns / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12029 Baugher Rd. Thurmont, MD 21788</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation, Inc.</b>		20c. Location - City or Town, State <b>5/9/96 Hampstead, MD</b>			
	21. Signature of Funeral Service Licensee <i>Catherine Q. Hartzler</i>				22. Name and Address of Facility <b>Hartzler Funeral Home New Windsor, MD</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Chest injuries complicating arteriosclerotic cardiovascular disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-6-96</b>		28b. Time of Injury <b>UNKNOWN M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <b>PASSENGER IN AUTO/FIXED OBJECT IMPACT</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROAD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>BAUGHER RD. &amp; AUBURN RD. FREDERICK CO., MD.</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>James A. Locke MD</i>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>MAY 07, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. A. Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 09 1996</b>		32. Registrar's Signature <i>John Davidson</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14595

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERVIN BEAN				2. Date of Death Month MAY Day 4 Year 1996				3. Time of Death 6:15 pm	
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death	
Funeral Director	5. Social Security Number 220-16-6135	6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F X	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jul 8, 1925	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Carroll	10c. City, Town or Location Hampstead				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 4240 Crystal Ct apt 2-D				10f. Zip Code 21074		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry AAI Corp			
	17. Father's Name (First, Middle, Last) Jacob Bean				18. Mother's Name (First, Middle, Maiden Surname) C. Blanche Kearchner					
	19a. Informant's Name/Relationship (Type, Print) Charlotte Kelley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3536 Beckleysville Rd, Millers, MD 21102					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem Park		Date 5/8/96		20c. Location - City or Town, State Cumberland, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eline Funeral Home 934 S Main St, Hampstead, md 21074					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. Anoxic Brain Injury Due to (or as a consequence of): b. Left Occipito-Parietal Intracerebral hemorrhage Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Atrial Fibrillation										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier U. Prakash, M.D.										
29c. License number N3572										
29d. Date signed (Month, Day, Year) May 4, 1996										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U. Prakash, Johns Hopkins Hospital, 600 North St. Paul St, Baltimore, Maryland										
31. Date filed (Month, Day, Year) MAY 06 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", of items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14596

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGIE ESTELLE BURRISS				2. DATE OF DEATH MONTH DAY YEAR APRIL 27, 1996		3. TIME OF DEATH 4:46 P M	
4. SOCIAL SECURITY NUMBER 578-40-8881D		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 25, 1901	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 3028 BEL PRE ROAD		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3028 BEL PRE ROAD	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) FRANK TURNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZA CLARK			
19a. INFORMANT'S NAME (Type/Print) EDNA M. QUEEN, DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3028 BEL PRE ROAD, SILVER SPRING, MD. 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) COLESVILLE CEMETERY		20c. LOCATION — City or Town, State 4/30/96 COLESVILLE, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber	
22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular disease DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis M. Hannon MD				29c. LICENSE NUMBER D23124		29d. DATE SIGNED (Month, Day, Year) 4/28/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Hannon, MD 3416 BRANDWOOD COURT; OLNEY MD 20832							
31. DATE FILED (Month, Day, Year) APR 29 1996				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14597

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Trunnell Burke				2. Date of Death Month Day Year April 20, 1996		3. Time of Death 11:15pm			
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing Center				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 577-84-2471		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 4, 1904	9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 708 Carter Road				10f. Zip Code 20852		10g. Citizen of What Country? United States			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Isaac H. Trunnell				18. Mother's Name (First, Middle, Maiden Surname) Victoria A. Porch					
	19a. Informant's Name/Relationship (Type, Print) Dorothy B. O'Donnell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Carter Road, Rockville, MD 20852					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		20d. Date 4/25/96			
	21. Signature of Funeral Service Licensee Michael D. Gibbons		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877							
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. cerebrovascular accident 7 days Due to (or as a consequence of): b. pneumonia 7 days Due to (or as a consequence of): c. peripheral vascular disease >1yr Due to (or as a consequence of): d. Anemia >1yr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier H. G. Rao		29c. License number D35792		29d. Date signed (Month, Day, Year) APRIL 22, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWAROOP. G. RAO; 50, W. EDMONSTON DR, ROCKVILLE, MD									
To Be Completed by Registrar	31. Date filed (Month, Day, Year) APR 26 1996		32. Registrar's Signature John Davidson							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 14598

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM R. BROCKMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 29, 1996</b>		3. TIME OF DEATH <b>11:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-36-5208</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 10, 1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>14508 HOMECREST RD.</b>			
10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>RET. - BUYER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RET. - BUYER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WHOLESALE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HAROLD W. BROCKMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDNA DORKIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>STEPHEN H. BROCKMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>166 THUNDERBIRD DR., LUSBY, MD. 20657</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY 5/1</b>		20c. LOCATION — City or Town, State <b>RIVERDALE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> M00091				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO. INC, SILVER SPRING, MD. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 day</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End stage renal disease, hypertension, Rhabdomyolysis, dehydration</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey A. Perlmutt MD</i>				29c. LICENSE NUMBER <b>D47188</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/30/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey A. Perlmutt MD, 6240 Monrovia Road, Rockville MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 02 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject.

2. The second part of the report is a description of the methods used in the study. This includes a discussion of the subjects, the instruments used, and the procedures followed.

3. The third part of the report is a presentation of the results of the study. This includes a discussion of the data collected and the conclusions drawn from it. The results are presented in a clear and concise manner, with appropriate use of tables and figures.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14599

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERIC R. BRENT

2. Date of Death

Month Day Year  
APRIL 18, 1996

3. Time of Death

10:20 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

578-80-0545

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 1, 1958

9. Birthplace (State or Foreign Country)

D. C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

926 Ray Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Bernard B. Brent

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Brown

19a. Informant's Name/Relationship (Type, Print)

Dorothy Brent

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

926 Ray Road, Hyattsville, Md. 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

4/23/96

20c. Location - City or Town, State

Washington, D. C.

21. Signature of Funeral Service Licensee

R. N. Horton

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.  
600 Kennedy Street, N. W.

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *CHRONIC OBSTRUCTIVE PULMONARY DISEASE*

Due to (or as a consequence of):

4-5 Mths

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *ACUTE INTERCURRENT DEPRESSIVE DISORDER*

Due to (or as a consequence of):

3-4 Mths

c. *SBPSIS*

Due to (or as a consequence of):

3-4 Mths

d. *TUBERCULOSIS*

2 Mths

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*PERIPHERAL VASCULAR DISEASE*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Samuel A. [Signature]*

29c. License number

D25766

29d. Date signed (Month, Day, Year)

April 19, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*SAMUEL A. [Signature] 100 R.N. HORTON CO. MORTICIAN 600 KENNEDY ST. N.W.*

31. Date filed (Month, Day, Year)

APR 30 1996

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14600

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES ALLEN BRADFIELD				2. Date of Death Month Day Year 4 24 96		3. Time of Death 9:30 pm	
	4a. Facility Name (If not institution, give street and number) 4 Lorraine Court				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 185-20-3648	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 13, 1929		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4 Lorraine Court			10f. Zip Code 20852		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Officer			16b. Kind of Business/Industry C. I. A.	
	17. Father's Name (First, Middle, Last) Robert Bradfield				18. Mother's Name (First, Middle, Maiden Surname) Sarah Hartzell			
	19a. Informant's Name/Relationship (Type, Print) Joan D. Bradfield				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) U. S. U. H. S.		Data 4-29-96		20c. Location - City or Town, State Bethesda, Maryland	
	21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Due to (or as a consequence of): b. None Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Brian G. Fuller, M.D.				29c. License number 665795		29d. Date signed (Month, Day, Year) 4/29/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN G. FULLER, M.D. Radiation Oncology Branch, NCI Bethesda, MD								
31. Date filed (Month, Day, Year) APR 30 1996				32. Registrar's Signature John Anderson				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14601

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSE ALBERTO BRACERO

2. Date of Death

Month Day Year  
APRIL 28 1996

3. Time of Death

5:49 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

583-20-3587

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 15, 1949

9. Birthplace (State or Foreign Country)

Puerto Rico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

625 Watts Branch Parkway

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Biomedical Engineer

16b. Kind of Business/Industry

National Institute of Health

17. Father's Name (First, Middle, Last)

Jose Bracero

18. Mother's Name (First, Middle, Maiden Surname)

Julia Vasquez

19a. Informant's Name/Relationship (Type, Print)

Irma Bracero

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

625 Watts Branch Parkway, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico Cemetery

Date

5/2/96

20c. Location - City or Town, State

Triangle, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd.W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37024

29d. Date signed (Month, Day, Year)

APRIL 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David G. Srouer M.D. 9901 Medical Center Drive, Rockville, Maryland 20850-3395

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



96 14602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID BLEECKER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>8:05A M</b>	
4. SOCIAL SECURITY NUMBER <b>099-12-8173</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 1, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6121 MONTROSE ROAD</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OFFICE WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN BLEECKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JENNY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MIRIAM LEVINE (SISTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15090 ASHLAND PLACE-DELRAY BEACH, FLORIDA 33484</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH DAVID CEMETERY</b>		DATE <b>4/25</b>		20c. LOCATION — City or Town, State <b>ELMONT, NEW YORK</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARDIOMYOPATHY (ISCHEMIC)</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>P. Talwar, M.D.</b>				29c. LICENSE NUMBER <b>D 36552</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 22, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>P. TALWAR 6121 MONTROSE ROAD. ROCKVILLE MD. 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14603

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Theodore Bergmann</b>				2. Date of Death Month <b>April</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>3:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>499-16-8819</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1921</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>300 Applegrove Road</b>				10f. Zip Code <b>20904-2745</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>Collage (1-4or 5+)</b> <b>5+</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>			16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Theodore Adolph Bergmann</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Clara Augusta Brandenburg</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Leola Ruth Bergmann</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 Applegrove Road, Silver Spring, Maryland 20904-2745</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul's Evangelical Lutheran Cemetery</b>		Data <b>5/4/96</b>		20c. Location - City or Town, State <b>Concordia, Missouri</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Gastrointestinal Bleed</b> Due to (or as a consequence of):  b. <b>Refractory Thrombocytopenia</b> Due to (or as a consequence of):  c. <b>Multiple Myeloma</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  a. <b>2 Days</b>  b. <b>6 Weeks</b>  c. <b>3 Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D08754</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>Thomas A. Bensinger M.D. 7525 Greeway Center Crive, Greenbelt, Maryland 20770</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



96 14604

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wasy1 Barnaj				2. DATE OF DEATH MONTH DAY YEAR April 30, 1996		3. TIME OF DEATH 5:20 AM M	
4. SOCIAL SECURITY NUMBER 220-60-6991		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1926	
8. BIRTHPLACE (State or Foreign Country) Ukraine				9a. FACILITY NAME (If not institution, give street and number) 3105 Kingtree Street		9b. CITY, TOWN OR LOCATION OF DEATH Wheaton	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Wheaton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3105 Kingtree Street	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? Ukraine		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Clerk		16b. KIND OF BUSINESS/INDUSTRY National Geographic	
17. FATHER'S NAME (First, Middle, Last) Mykola Barnaj				18. MOTHER'S NAME (First, Middle, Maiden Surname) Salamonia Hawryluk			
19a. INFORMANT'S NAME (Type/Print) Nicolas Barnaj / Brother				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9518 Flower Avenue, Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Andrew Ukr. Ch. Mem. Cem. 5/3/96		20c. LOCATION — City or Town, State S. Boundbrook, NJ	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>LIVER FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>METASTATIC CANCER</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>CANCER OF CARCINOMA</u> DUE TO (OR AS A CONSEQUENCE OF):							
d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D17368		29d. DATE SIGNED (Month, Day, Year) 5/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley Schwartz, M.D. 2101 Medical Park Drive, #201, Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) MAY 03 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14605

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTIE BARER</b>				2. Date of Death Month <b>APRIL</b> Day <b>25</b> Year <b>1996</b>				3. Time of Death <b>6:45 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>9701 FIELDS ROAD #1508</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>				4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>138-20-4370</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) <b>FEB. 10, 1902</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GAITHERSBURG</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9701 FIELDS ROAD #1508</b>		10f. Zip Code <b>20878</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>Collage</b>			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE SECRETARY</b>		16b. Kind of Business/Industry <b>NEWSPAPER</b>		17. Father's Name (First, Middle, Last) <b>NATHAN HOROWITZ</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>NETTIE ENGEL</b>		19a. Informant's Name/Relationship (Type, Print) <b>SANFORD ENGEL (SON)</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. LEBANON CEMETERY</b>		20c. Location - City or Town, State <b>ISELIN, NEW JERSEY</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cardiopulmonary arrest.</b> Due to (or as a consequence of):  b. <b>Atrial fibrillation.</b> Due to (or as a consequence of):  c. <b>Stage IV chronic lymphocytic leukemia</b> Due to (or as a consequence of):  d. <b>lung infiltrate</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>S. Unterebach MD.</b>		29c. License number <b>D29365</b>		29d. Date signed (Month, Day, Year) <b>APRIL 26, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>8909 Shady Grove Court Gaithersburg, MD 20877</b>			
	31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature <i>[Signature]</i>		33. State Registrar		34. State Registrar		35. State Registrar			

Baltimore, Maryland 21215-0020

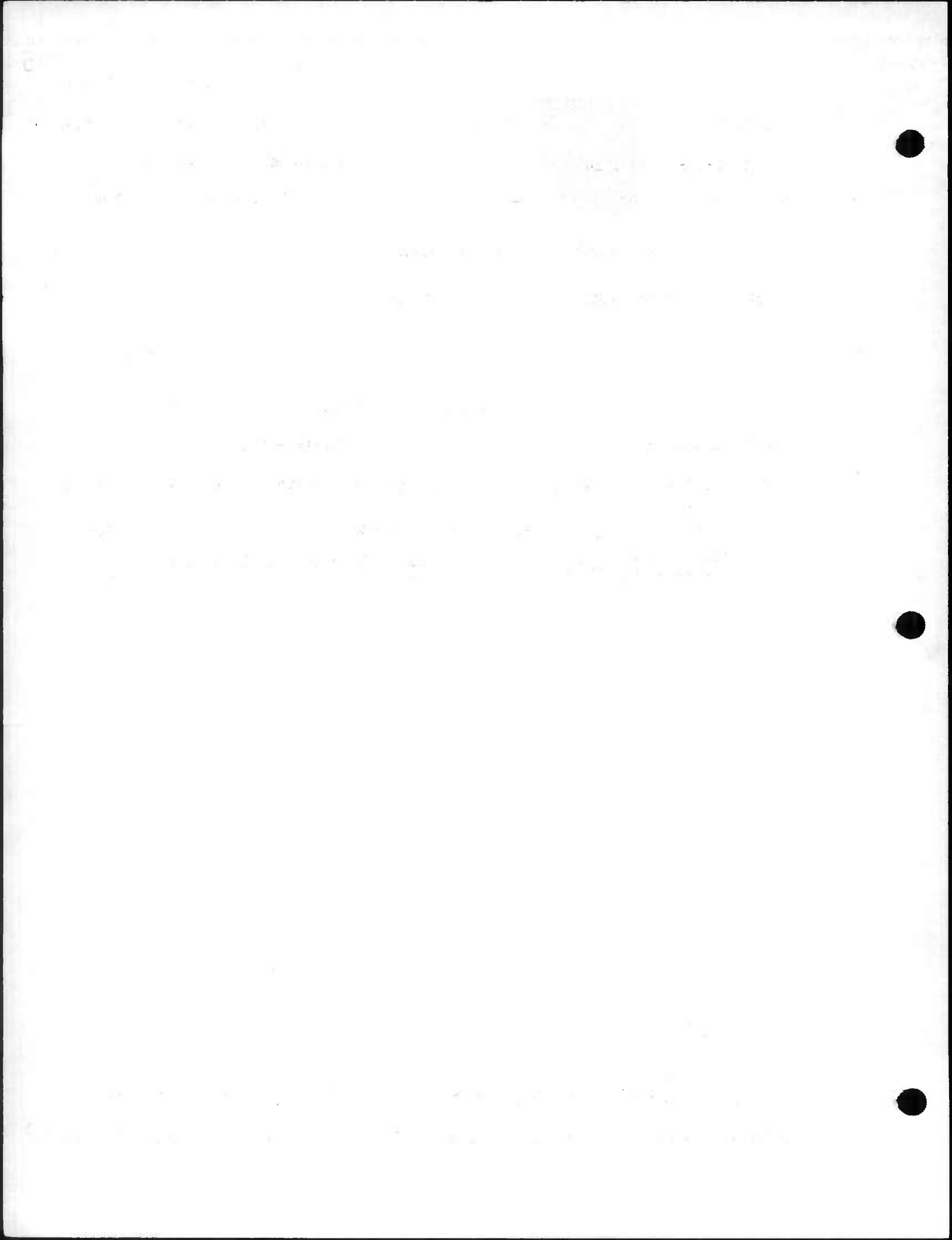
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14606

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary S. Burns</b>					2. Date of Death Month Day Year <b>April 27, 1996</b>		3. Time of Death <b>3:57 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>9501 52nd Avenue</b>					4b. City, Town, or Location of Death <b>College Park</b>		4c. County of Death <b>Prince George's</b>						
Funeral Director	5. Social Security Number <b>577-38-0417</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 14, 1923</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>						
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>College Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>9501 52nd Avenue</b>			10f. Zip Code <b>20740</b>		10g. Citizen of What Country? <b>USA</b>								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>								
	17. Father's Name (First, Middle, Last) <b>Arthur M. Stewart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Olive E. Beers</b>									
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Harry S. Burns</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8109 High Meadow Court, Ellicott City, MD 21043</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Date <b>4/30/96</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>							
	21. Signature of Funeral Service Licensee <i>Timothy G. Campbell</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">           e. <b>Metastatic Cancer Pancreas</b>            Due to (or as a consequence of):            _____            Due to (or as a consequence of):            _____            Due to (or as a consequence of):            _____            Due to (or as a consequence of):            _____         </td> <td rowspan="4">Approximate Interval Between Onset and Death <b>11 mos.</b></td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>									Immediate Cause (Final disease or condition resulting in death)	e. <b>Metastatic Cancer Pancreas</b> Due to (or as a consequence of): _____ Due to (or as a consequence of): _____ Due to (or as a consequence of): _____ Due to (or as a consequence of): _____	Approximate Interval Between Onset and Death <b>11 mos.</b>		
Immediate Cause (Final disease or condition resulting in death)	e. <b>Metastatic Cancer Pancreas</b> Due to (or as a consequence of): _____ Due to (or as a consequence of): _____ Due to (or as a consequence of): _____ Due to (or as a consequence of): _____	Approximate Interval Between Onset and Death <b>11 mos.</b>												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Martin D. Weltz M.D.</i>		29c. License number <b>D 23743</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Martin D. Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770</b>														
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature <i>John Davidson</i>												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 14607

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lucille A. Bible</b>				2. Date of Death Month Day Year <b>April 26 1996</b>		3. Time of Death <b>2051</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>217-18-4957</b>		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 9, 1921</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>328 Union Church Road</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>n/a</b>		
	17. Father's Name (First, Middle, Last) <b>George W. Wagner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etta Alma Mongold</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Melissa A. Copen</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>464 Elk Mills Road - Elkton, MD 21921</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gilpin Manor Memorial Park</b>		Date <b>4-30 1996</b>		20c. Location - City or Town, State <b>Elkton, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Donald S. Hicks</b>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery disease, Prosthetic aortic valve, Dilated Cardiomyopathy, Hemorrhagic gastritis, Digitalis Toxicity</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>Monte Makour, MD</b>				29c. License number <b>D-44783</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MONTA MAKOUR, MD 111 W. HIGH ST., ELKTON, MD 21921</b>							
31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>				32. Registrar's Signature <b>Julia Harrison-Randall</b>				



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State of Maryland / Department of Health and Mental Hygiene

96 14608

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Natalie Nancy Beecham</b>				2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>0541</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>016-12-2333</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 4 1922</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>515 St. Charles Street</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>Samuel Franks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Gutterman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lee M. Beecham</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>515 St. Charles St., Elkton, MD. 21921</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co.</b>		Date <b>5-4-96</b>		20c. Location - City or Town, State <b>West Chester, PA.</b>		
21. Signature of Funeral Service Licensee <i>Donald S. Hicks</i>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, MD. 21921</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS SYNDROME</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c. CHRONIC LYMPHOCYTIC LEUKEMIA</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>12 HRS</b> <b>48 HRS</b> <b>38 YRS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANOMALY TO PNEUMIA</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William Ranzulli</i>		29c. License number <b>D 44102</b>		29d. Date signed (Month, Day, Year) <b>5/3/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Ranzulli M.D. 901 Warburton Rd Elkton, Md 21921</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>				32. Registrar's Signature <i>John A. Ranzulli</i>				



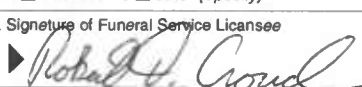
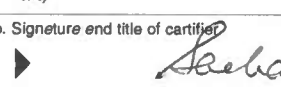
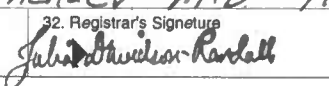
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State of Maryland / Department of Health and Mental Hygiene

96 14609

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ira Graham Boulden</b>				2. Date of Death Month Day Year <b>April 29 1996</b>		3. Time of Death <b>2150</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>177-10-9622</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 20, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>North East</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>81 Charbon Lane</b>			10f. Zip Code <b>21901</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>US Army WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Boiler General Maintenance- Repair</b>		16b. Kind of Business/Industry <b>Government Testing Facility</b>		
	17. Father's Name (First, Middle, Last) <b>Walter Henry Boulden</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Phillips</b>				
	19e. Informant's Name/Relationship (Type, Print) <b>Annie K. Boulden</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>81 Charbon Lane, North East, MD 21901</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>North East Methodist Cem</b>		Date <b>5/3 1996</b>	20c. Location - City or Town, State <b>North East, Maryland</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Crouch Funeral Home 127 South Main Street, North East, MD 21901</b>				
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Coronary Artery disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							<b>9 days</b>          <b>10 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D23322</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sheel Mohan Sachdev M.D. 118 North St Ste 3B. Elkton, Md 21921</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14610

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Lamar Bender				2. Date of Death Month April Day 26, 1996 Year				3. Time of Death 1:06 AM	
	4e. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-5250		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth Month Day Year Oct. 16, 1920		9. Birthplace (State or Foreign Country) Virginia							
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 807 Motter Avenue				10f. Zip Code 21701			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter			16b. Kind of Business/Industry US Government		
	17. Father's Name (First, Middle, Last) George BENDER				18. Mother's Name (First, Middle, Maiden Surname) Fannie MAYNE					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara B. Leadbetter, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Handel Road, Westerly, Rhode Island 02891					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery April 29, 1996			20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee Richard E. Hryf MOO255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701					
	Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)									1 DAY	
a. PEROTINITIS DUE TO BOWEL PERFORATION									1 DAY	
Due to (or as a consequence of):										
b. ACUTE RENAL FAILURE									1 DAY	
Due to (or as a consequence of):										
c. {										
Due to (or as a consequence of):										
d. {										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Sayed Zaidi		29c. License number D43091		29d. Date signed (Month, Day, Year) 4-26-96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAEED ZAIDI 801 TOLL HOUSE AVE, FREDERICK Md. 21701									
	31. Date filed (Month, Day, Year) APR 29 1996		32. Registrar's Signature John Andrew R...							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

APR 2 1994

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 14611

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lewis Bradley Marman, Sr.				2. Date of Death Month Day Year April 26, 1996		3. Time of Death 12:40AM								
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick								
Funeral Director	5. Social Security Number 214-10-1931		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Dec. 2, 1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent														
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick								10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 804 Young Place				10f. Zip Code 21702				10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier				16b. Kind of Business/Industry U.S. Postal Service							
17. Father's Name (First, Middle, Last) Harry Charles Marman						18. Mother's Name (First, Middle, Maiden Surname) Mollie Hoffman									
19a. Informant's Name/Relationship (Type, Print) Edna J. Marman, Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Young Place, Frederick, MD 21702									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, April 30, 1996				Date		20c. Location - City or Town, State Frederick, Maryland					
21. Signature of Funeral Service Licensee Allan H Ruby M00703						22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Atherosclerotic Heart Disease</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last														Approximate Interval Between Onset and Death <u>years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u>															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred					
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier Casper E. Cline						29c. License number D16428				29d. Date signed (Month, Day, Year) 4/26/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline 300 West 9th Street Frederick Md. 21701															
31. Date filed (Month, Day, Year) APR 29 1996				32. Registrar's Signature [Signature]											

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14612

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) William Rudolph Bruce				2. Date of Death Month April Day 23, Year 1996		3. Time of Death 12:26 PM			
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 250 52 3208		6. Sex 15 M 20 F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-1-33	9. Birthplace (State or Foreign Country) S. Carolina		
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits 10 Yes 20 No		
	10e. Street and Number 7831 Gambril Rd.				10f. Zip Code 21702		10g. Citizen of What Country? United States			
	11. Marital Status 10 Navar Married 20 Married 30 Widowed 40 Divorced		12. Was Decedant Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Records Management			16b. Kind of Business/Industry U.S. Military		
	17. Father's Name (First, Middle, Last) Ernest Bruce				18. Mother's Name (First, Middle, Maiden Summa) Louise Talley					
	19a. Informant's Name/Relationship (Type, Print) E. Elaine Bruce / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7831 Gambril Rd./ Frederick, Maryland 21702					
	20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Data 5-10-96		20c. Location - City or Town, State Arlington, Virginia			
	21. Signature of Funeral Service Licensee <i>Raymond P. Talley</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Maryland 21702					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CARDIOGENIC SHOCK Due to (or as a consequence of): b. ACUTE ANTERIOR MYOCARDIAL INFARCT Due to (or as a consequence of): c. DIABETES Due to (or as a consequence of): d. HYPERTENSION  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 12 HR 36 HR	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown	
24a. Was an autopsy performed? 10 Yes 20 No								24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 10 Yes 20 No		26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 80 Other (Specify)							
	27. Manner of Death 10 Natural 50 Pending investigation 20 Accident 60 Could not be determined 30 Suicide 40 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 10 Yes 20 No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Sherman Kahan MD</i>				29c. License number		29d. Date signed (Month, Day, Year) 4-26-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S KAHAN 915 TOLLOUSE AVE #307 FREDERICK MD 21701									
State Registrar	31. Date filed (Month, Day, Year) APR 29 1996				32. Registrar's Signature <i>Paula R. Ruffolo</i>					

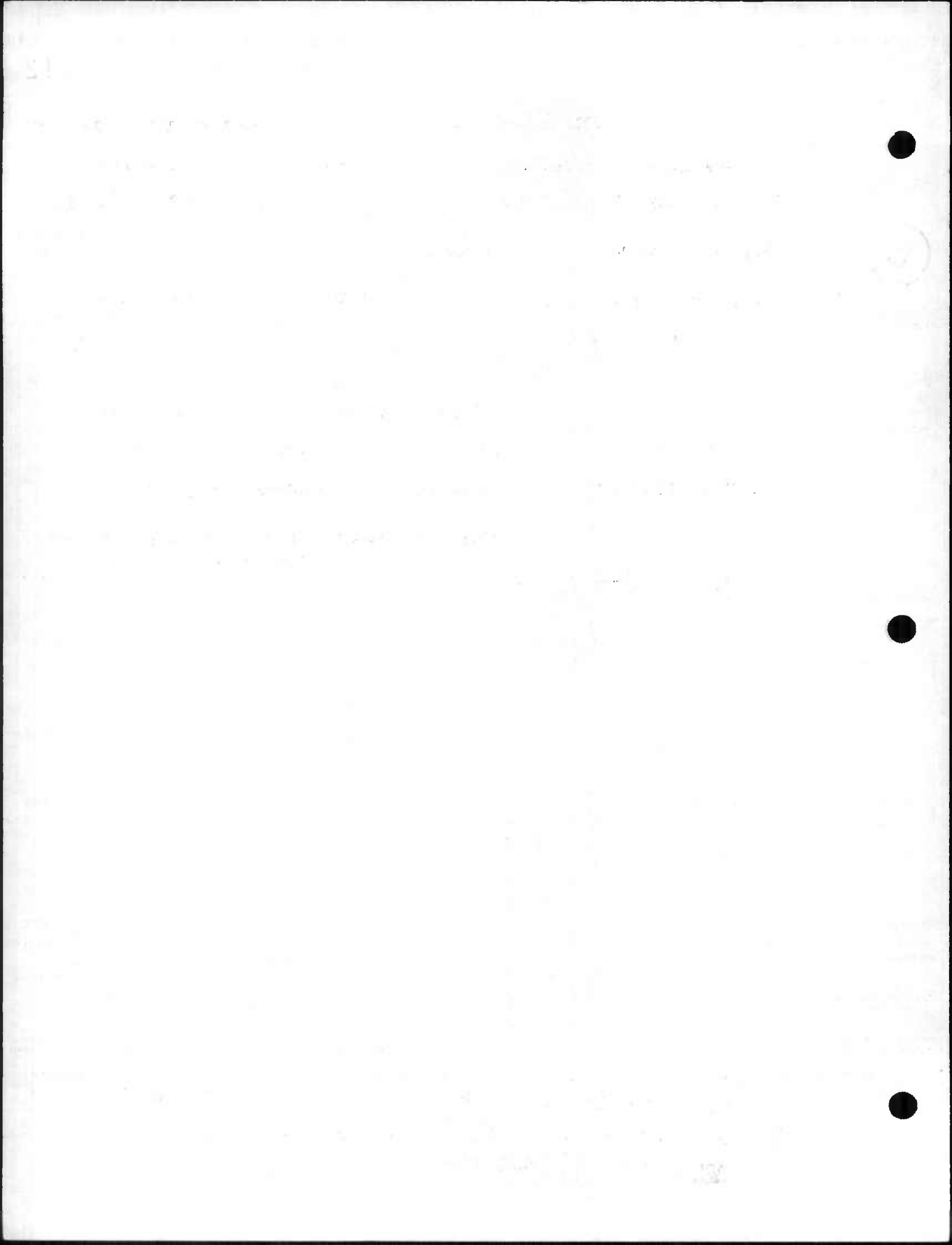
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14613

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JUNE Elizabeth BOWMAN						2. Date of Death Month Day Year APRIL 22, 1996		3. Time of Death 8:30 p.m.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 577-20-7524		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 17, 1922		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Middletown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4032 Valley View Rd.				10f. Zip Code 21769		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) JAMES MORRISON						18. Mother's Name (First, Middle, Maiden Surname) ELSIE AUSTIN			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) FLOYD L. BOWMAN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4032 Valley View Rd./ Middletown, Md. 21769					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven memorial		Date 4-26-96		20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee <i>Raymond Petersen</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702					
	23a. Part I. State the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>NA</i>		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Dr. Abdul Jameed</i> MD				29c. License number D 18063			29d. Date signed (Month, Day, Year) 4/24/96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Abdul Jameed, M.D. / 801 Toll House Ave. / Frederick, Md. 21701									
State Registrar	31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature <i>William Randolph</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3



96 14614

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Clara Crowl Bohrer</u>				2. DATE OF DEATH MONTH DAY YEAR <u>April 21 1996</u>		3. TIME OF DEATH <u>12:00 PM</u>	
4. SOCIAL SECURITY NUMBER <u>213-09-4445</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>89</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 10 1906</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Meridian Nursing Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Frederick</u>		9c. COUNTY OF DEATH <u>Frederick</u>	
10a. STATE <u>MD</u>				10b. COUNTY <u>Frederick</u>		10c. CITY, TOWN OR LOCATION <u>Brunswick</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>512 Ninth Avenue</u>				10f. ZIP CODE <u>21716</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Homemaker</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Walter Elias Crowl</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alta Jane Riker</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Roy Lee Crowl</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>510 Ninth Avenue, Brunswick, MD 21716</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Park Heights Cemetery 4/25 Brunswick, MD</u>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Barbara A. Williams, Owner</u>				22. NAME AND ADDRESS OF FACILITY <u>John T. Williams Funeral Home 100 Petersville Rd., Brunswick MD</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cerebrovascular disease</u>							
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's disease, osteoarthritis</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>J. Christopher Fleming</u>				29c. LICENSE NUMBER <u>D37178</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-22-96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>J. Christopher Fleming MD 610 Ninth Ave., Brunswick, MD 21716</u>							
31. DATE FILED (Month, Day, Year) <u>APR 26 1996</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14615

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Bentley				2. Date of Death Month Day Year April 20, 1996		3. Time of Death 11:15 p.m.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 384-38-1432		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1914	
	9. Birthplace (State or Foreign Country) Michigan		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 8206 Skipwith Drive		10f. Zip Code 21702		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Division Operator		16b. Kind of Business/Industry Handicap Institution				
17. Father's Name (First, Middle, Last) Roy Bentley				18. Mother's Name (First, Middle, Maiden Surname) Alice Grace				
19a. Informant's Name/Relationship (Type, Print) Amy Jardine / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8206 Skipwith Drive, Frederick, MD 21702				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 4/22/96 Hagerstown, Maryland				
21. Signature of Funeral Service Licensee Paul T. B. MacKay		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Alzheimer's dementia</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Piece of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Martha Pierce MD		29c. License number D 46248		29d. Date signed (Month, Day, Year) 4/21/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Martha Pierce 110 Baughmans Lane, Frederick, MD								
31. Date filed (Month, Day, Year) APR 20 1996		32. Registrar's Signature Julia Anderson-Randall						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 28 is marked other than "natural", or item 29 is marked other than "natural", the Medical Examiner must be notified at 0008.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14616

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARSHALL JOSEPH BARGER SR.				2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 1:32 p.m.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 220-09-7886	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 9, 1921	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Brunswick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 109 West B Street			10f. Zip Code 21716		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-Employed			16b. Kind of Business/Industry General Hauling			
	17. Father's Name (First, Middle, Last) Marshall Edwin Barger				18. Mother's Name (First, Middle, Maiden Surname) Claudie Moler				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elsie M. Barger, Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 West B Street, Brunswick, MD 21716					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frederick Mem. Park, April 24, 1996		Date Frederick, Maryland		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Allan H. Ruby MO0703			22. Name and Address of Facility Keeney & Bastford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. SPINAL CORD ISCHEMIA (PARALYSIS) Due to (or as a consequence of): c. CARCINOMA OF THE LUNG. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 4 DAYS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE ARTERIOCLEROSIS.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number MA: 047684		29d. Date signed (Month, Day, Year) 4/21/96		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JEFFREY J. SPILLANE MD / 74 THOMAS JONASSON DR FREDERICK MD 21701								
State Registrar	31. Date filed (Month, Day, Year) APR 24 1996		32. Registrar's Signature John Andrew Randall						

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 14617

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Claude C. Boyles</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>19</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>9:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>232-09-1591</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>93</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 20, 1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Ijamsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4326 Prices Distillery Road</b>				10f. ZIP CODE <b>21754</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James O. Boyles</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary L. Carter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Genevieve G. Boyles</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4326 Prices Distillery Rd., Ijamsville, Md. 21754</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bethesda Meth. Cemetery 4/23/96</b>		20c. LOCATION — City or Town, State <b>Damascus, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Olin L. Molesworth</i>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>4 Days</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Alzheimers</b> DUE TO (OR AS A CONSEQUENCE OF):				Years	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Saeed A. Zaidi</i>				29c. LICENSE NUMBER <b>043091</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 22, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Saeed A. Zaidi, M.D. 801 Toll House Ave., Frederick, Md. 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1996</b>		32. REGISTRAR'S SIGNATURE <i>Juan Sanchez-Rodriguez</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings and a comparison of the results with previous research. The final part of the report is a conclusion and a list of references.

The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings and a comparison of the results with previous research. The final part of the report is a conclusion and a list of references.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14618

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHIRLEY LOUISE BROHAWN</b>				2. Date of Death Month <b>MAY</b> Day <b>04</b> Year <b>1996</b>		3. Time of Death <b>1050</b>	
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>218-16-7185</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 14 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>605 Roslyn Ave.</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>assembly line</b>			16b. Kind of Business/Industry <b>electronics mfg.</b>	
17. Father's Name (First, Middle, Last) <b>Morris Mowbray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kilda Dillon</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Hubert F. Brohawn / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>605 Roslyn Ave. Cambridge MD 21613</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. Veterans Cemetery</b>		Data <b>5/7</b>		20c. Location - City or Town, State <b>Hurlock Maryland</b>
21. Signature of Funeral Service Licensee <i>Kenneth R. Thomas Jr.</i>				22. Name and Address of Facility <b>Thomas Funeral Home 700 Locust St. Cambridge, MD 21613</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>congestive heart failure</b> Due to (or as a consequence of): b. <b>acute myocardial infarction</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="position: absolute; left: 300px; top: 500px; font-size: 4em;">}</div>								Approximate Interval Between Onset and Death <b>7d</b> <b>7d</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute renal failure, chronic obstructive pulmonary disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>David G. Oliver</i>				29c. License number <b>039749</b>		29d. Date signed (Month, Day, Year) <b>5/4/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David G Oliver MD 503 Dutchmans Lane Easton MD 21601</b>								
31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14619

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte LaRue Black				2. Date of Death May 3, 1996				3. Time of Death 4:25 PM	
	4a. Facility Name (If not institution, give street and number) 106 S. Main St.				4b. City, Town, or Location of Death Union Bridge				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 219-34-5499		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 8, 1912		9. Birthplace (State or Foreign Country) Maryland	
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location New Windsor		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 9363 Albaugh Rd.				10f. Zip Code 21776		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farm wife/homemaker				16b. Kind of Business/Industry dairy			
	17. Father's Name (First, Middle, Last) Charles Keeney				18. Mother's Name (First, Middle, Maiden Surname) Hannah Fogle					
	19a. Informant's Name/Relationship (Type, Print) Selby M. Black/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 S. Main St. Union Bridge, MD 21791					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chapel Cemetery		Date 5/6/96		20c. Location - City or Town, State nr. Libertytown, MD			
	21. Signature of Funeral Service Licensee Catherine O. Hartzler				22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma, Pancreas Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4mo.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma breast Coronary heart disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. H. Carrico RE, MD		29c. License number D00906		29d. Date signed (Month, Day, Year) 5/3/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. H. Carrico RE, MD P.O. Box 1110 Union Bridge MD 21791										
31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature John Andrew Randall								

Baltimore, Maryland 21215-0020 [77]

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14620

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIAS NATHANIEL BLACK</b>			2. Date of Death Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>2015 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GARRETT MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>OAKLAND</b>		4c. County of Death <b>GARRETT COUNTY</b>	
Funeral Director	5. Social Security Number <b>213-21-2153</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1977</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>106 W. Pennington Street</b>			10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Surveyor</b>		16b. Kind of Business/Industry <b>Surveying</b>		
17. Father's Name (First, Middle, Last) <b>Lawrence N. Black</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Coleen Graham</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Lawrence N. Black, Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 W. Pennington St., Oakland, Maryland 21550</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrett Co. Mem. Gardens</b>		Data <b>4/30/96</b>		20c. Location - City or Town, State <b>Oakland, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St., Oakland, MD 21550</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE INJURIES</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>Sudden</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>4-27-1996</b>		28b. Time of Injury <b>1915 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>		28d. Describe how injury occurred <b>PASSENGER EJECTED FROM AUTO</b>			
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>MOSSER ROAD</b>					
29a. Certifier (Check one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>APRIL 28, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14621

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND CHARLES BAKER

2. Date of Death

Month Day Year  
May 5 1996

3. Time of Death

10:30 pm

4a. Facility Name (If not institution, give street and number)

Mallard Bay Nursing Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

214-07-9140

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 06 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5431 White Hall Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

maintenance worker

16b. Kind of Business/Industry

state hospital

17. Father's Name (First, Middle, Last)

Charles Allen Baker

18. Mother's Name (First, Middle, Maiden Surname)

Grace Coulbourne

19a. Informant's Name/Relationship (Type, Print)

Michael L. Baker / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5433 White Hall Rd. Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dorchester Memorial Park

Date

5/8

20c. Location - City or Town, State

Cambridge Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Moore Jr.

22. Name and Address of Facility

Thomas Funeral Home

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Ischemic Colitis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

12 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Angiogram Heart Failure

Due to (or as a consequence of):

12 mos

c. Coronary Heart Disease

Due to (or as a consequence of):

12 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Fadden

29c. License number

D26388

29d. Date signed (Month, Day, Year)

05-07-1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. Fadden 302 Collins Ave Hurlock Md 21643

31. Date filed (Month, Day, Year)

MAY 7 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items: 1,17,18 per Ex wife 6/21/96 G-736 reb  
 Items: 23 part 1,27,28a,b,c,d,e,f per State of Maryland Department of Health and Mental Hygiene  
 Items: 1 per F.H. G-735 5/17/96 reb

96 14622

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT EUGENE COLWELL JR.</b>		2. Date of Death Month <b>APRIL</b> Day <b>30</b> Year <b>1996</b>		3. Time of Death <b>3:15 P.M.</b>
	4e. Facility Name (If not institution, give street and number) <b>7638 AIR PARK ROAD</b>		4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>336-46-9331</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>OCT. 21, 1951</b>		9. Birthplace (State or Foreign Country) <b>ILL.</b>		
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>MONT.</b>		10c. City, Town or Location <b>GAITHERSBURG</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>7618 AIRPARK RD.</b>		10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>		
	16. Kind of Business/Industry <b>COMPUTERS</b>		17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMPUTER TECHNICIAN</b>		
	18. Decedent's Name (First, Middle, Maiden Surname) <b>HARRIET DELORES WESTON</b>		19. Informant's Name/Relationship (Type, Print) <b>PEGGY Bishop</b>		
	20. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>BALTO. CO. MD.</b>
	21. Signature of Funeral Service Licensee <b>Thomas J. Skanda Jr.</b>		22. Name and Address of Facility <b>SKANDA FH. 2829 HUDSON ST. BALTO., MD. 21224</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>e. CARBON MONOXIDE INTOXICATION</b> Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <b>Positive</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>GARAGE</b>		
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of injury (Month, Day, Year) <b>found 4/30/96</b> 28b. Time of Injury <b>1:45</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred <b>SUBJECT INHALED EXHAUST FUMES FROM RUNNING CAR PARKED IN AN ENCLOSED GARAGE</b> 28f. Location (Street and Number or Rural City or Town, State) <b>7638 AIR PARK RD. GAITHERSBURG, MD. 20879</b>		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>Margaret Dreyer</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MALYNDRA P. KOLAR MD. 111 Penn Street, Baltimore, Maryland 21201</b>				
	31. Date filed (Month, Day, Year) <b>MAY 17 1996</b>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14623

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>BOBBY COLLINS</b>				2. Date of Death Month Day Year <b>MAY 3, 1996</b>		3. Time of Death <b>12:45 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>Baltimore City</b>	
5. Social Security Number <b>234-64-0091</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 26 1940</b>	
9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5915 Ripley Park Drive</b>		10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Police Officer</b>		16b. Kind of Business/Industry <b>Public Protection</b>			
17. Father's Name (First, Middle, Last) <b>Charlie Collins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Corba Lockhart Collins</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jean Collins (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5915 Ripley Park Drive La Plata, MD 20646</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans</b>		20c. Location - City or Town, State <b>5-9-96 Cheltenham, MD</b>		20d. Date	
21. Signature of Funeral Service Licensee <b>John H. Eberwein</b>		22. Name and Address of Facility <b>J.H. Eberwein Mortuary</b>		22. Address of Facility <b>11855 Holly La Waldorf, MD 20601</b>		22. City, State, Zip Code	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>HYPOTENSION</b> Due to (or as a consequence of): b. <b>VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of): c. <b>ISCHEMIC CARDIOMYOPATHY</b> Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death <b>10 minutes</b> <b>10 minutes</b> <b>12 Years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24e. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings evaluable prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robyn D. Anderson, MD</b>		29c. License number <b>MD2000</b>		29d. Date signed (Month, Day, Year) <b>May 3, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBYN D. ANDERSON TOWER 110 600 N. Wolfe St. Baltimore MD 21287</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Julia Anderson Randall</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

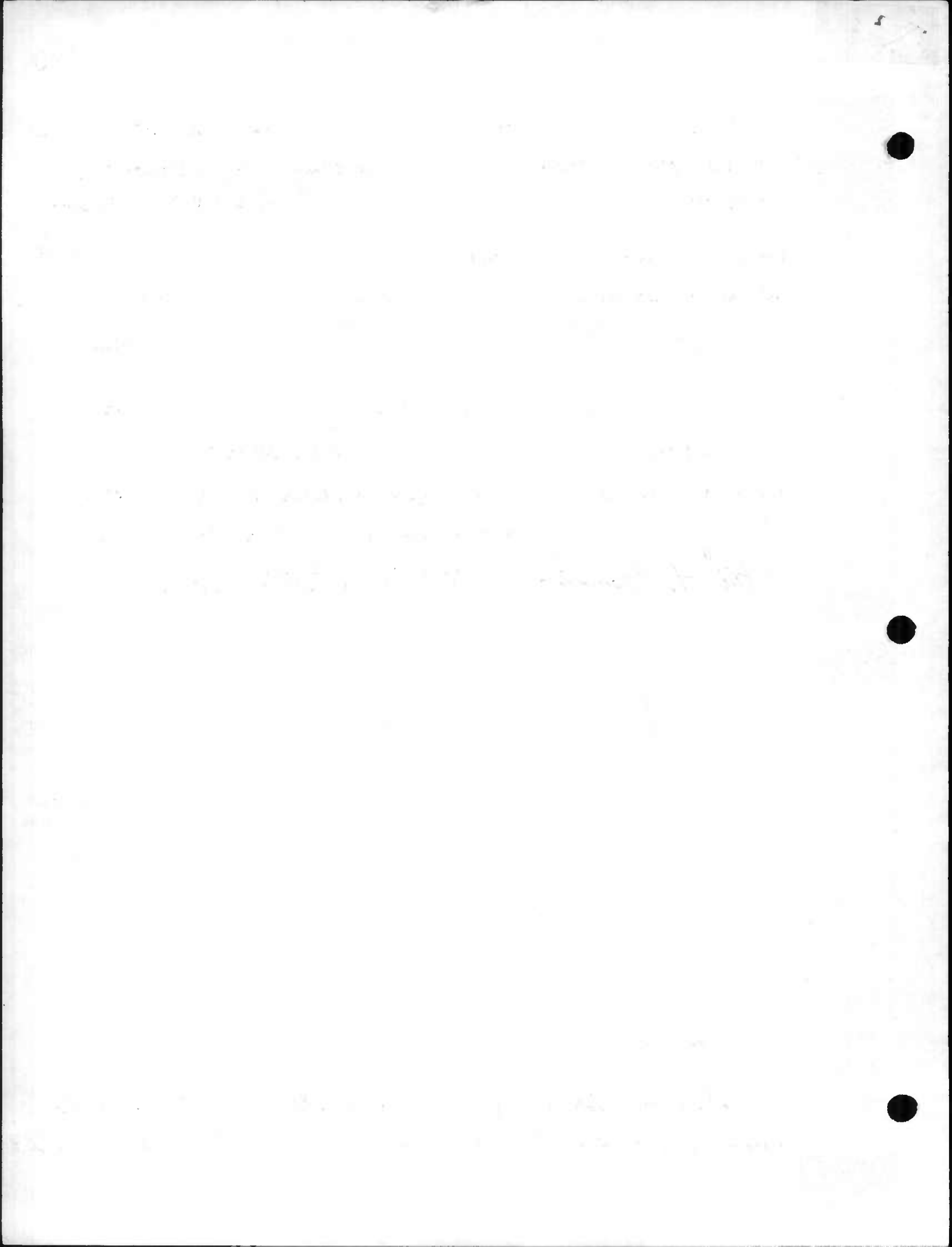
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14624

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laura CALDWELL</b>				2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>7:05 AM</b>	
	4e. Facility Name (If not Institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>578-10-7716</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 25, 1898</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Adelphi</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>United States</b>		10a. Street and Number <b>2407 Kirston Street</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foster Grandparent</b>		16b. Kind of Business/Industry <b>Great Oaks Center</b>		17. Father's Name (First, Middle, Last) <b>Richard Clubb</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Jane Austin</b>		19a. Informant's Name/Relationship (Type, Print) <b>Jane C. Adolph</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Baptist Church Cemetery</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <b>Acute myocardial infarction</b> Due to (or as a consequence of): b. <b>congestive heart failure</b> Due to (or as a consequence of): c. <b>ischemic cardiomyopathy</b> Due to (or as a consequence of): d. <b>Hypertension</b>		Approximate Interval Between Onset and Death <b>1 week</b> <b>1 week</b> <b>years</b> <b>years</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <b>A. Shaigany</b>		29c. License number <b>D-17540</b>		29d. Date signed (Month, Day, Year) <b>4, 29, 96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Asghar Shaigany 5632 Annapolis Road Suite 12 Bladensburg, MD 20710</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature <b>J. H. Anderson</b>		33. Date of Death <b>April 28 1996</b>		34. Time of Death <b>7:05 AM</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14625

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Frances Canning</b>				2. Date of Death Month <b>May</b> Day <b>1</b> , Year <b>1996</b>		3. Time of Death <b>9:05 PM</b>													
	4a. Facility Name (If not Institution, give street and number) <b>321 University Blvd. West, Apt 136</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>													
Funeral Director	5. Social Security Number <b>577-26-6711</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs., last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 21, 1916</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	10e. Street and Number <b>321 University Blvd. West Apt. 136</b>				10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>USA</b>													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>													
	17. Father's Name (First, Middle, Last) <b>Ernest F. Floegel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva W. Brannon</b>															
	19a. Informant's Name/Relationship (Type, Print) <b>Thomas J. Canning, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9223 Oregold Court, Laurel, Maryland 20708</b>															
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>5/2/96</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>													
	21. Signature of Funeral Service Licensee <b>Timothy G. Campbell</b>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</b>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Intestinal Obstruction/Dehydration</b></td> <td><b>&lt;1 week</b></td> </tr> <tr> <td>b.</td> <td><b>Colon Cancer</b></td> <td><b>4 months</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Intestinal Obstruction/Dehydration</b>	<b>&lt;1 week</b>	b.	<b>Colon Cancer</b>	<b>4 months</b>	c.			d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Intestinal Obstruction/Dehydration</b>	<b>&lt;1 week</b>																	
	b.	<b>Colon Cancer</b>	<b>4 months</b>																	
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History Throat Cancer</b> <b>History of Bone Cancer</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <b>Dr. Lillianfield, MD</b>				29c. License number <b>028977</b>		29d. Date signed (Month, Day, Year) <b>5/2/96</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LISA LILIENTFIELD, MD 7676 New Hampshire Ave Langley Pk, MD</b>																				
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <b>John Davidson</b>																

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





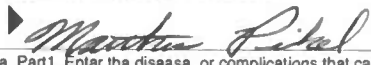

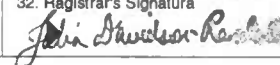
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

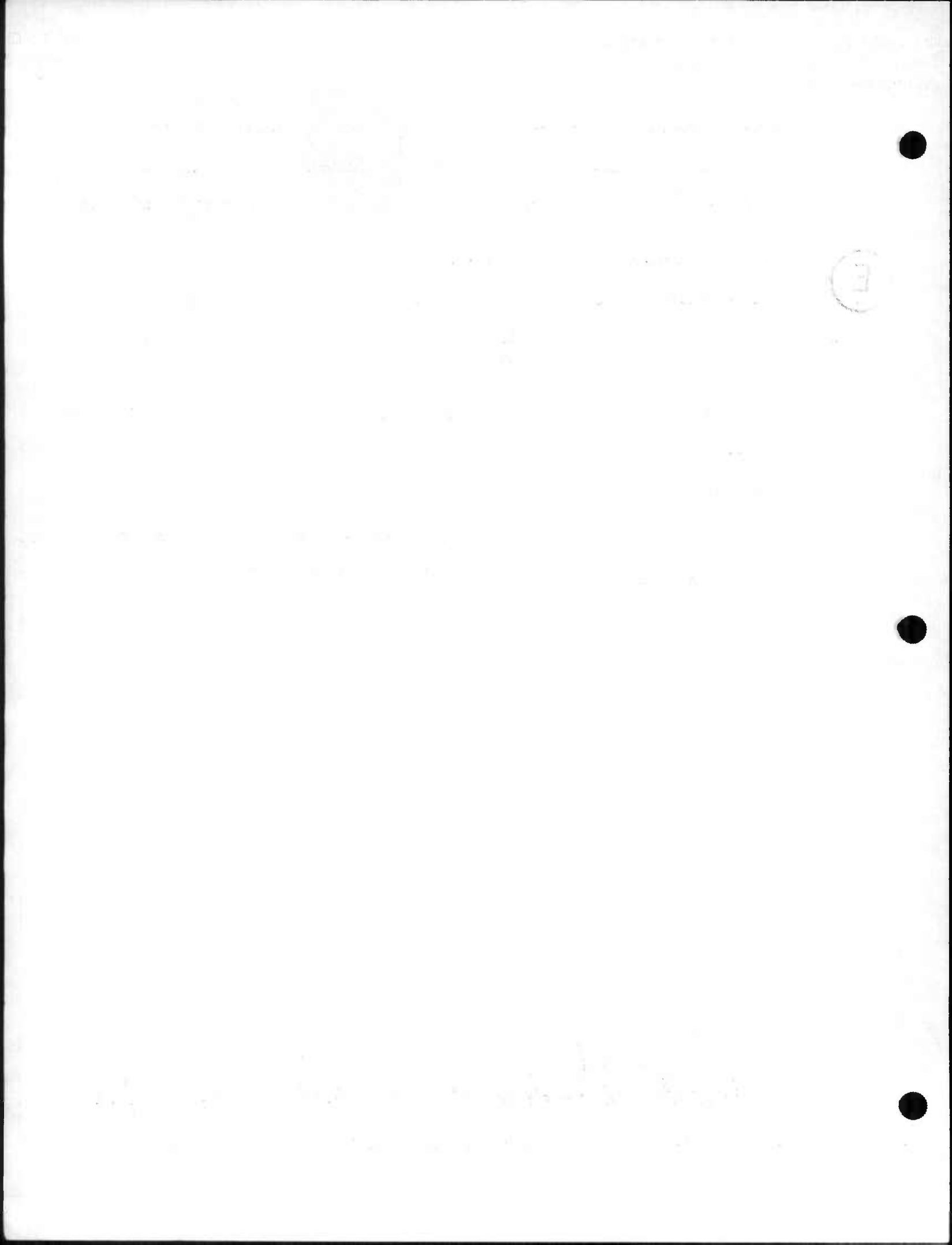
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14626

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Edward Chaney</b>				2. Date of Death Month <b>April</b> Day <b>25</b> , Year <b>1996</b>				3. Time of Death <b>3:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care at Fernwood</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>212-24-1678</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 20, 1929</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>10220 Meredith Avenue</b>				10f. Zip Code <b>20910</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1946-</b> If Yes, Give Year or Dates: <b>1949</b>	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Diesel Mechanic</b>				16b. Kind of Business/Industry <b>Metro Corporation</b>				17. Father's Name (First, Middle, Last) <b>Alton Chaney</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Malone</b>				19a. Informant's Name/Relationship (Type, Print) <b>Ines Pearl Chaney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10220 Meredith Avenue, Silver Spring, MD 20910</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Central Chapel Cemetery</b>				20c. Location - City or Town, State <b>Glengary, West Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 20901 500 University Boulevard W., Silver Spring, MD</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>respiratory failure</b> Due to (or as a consequence of): b. <b>lung cancer</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <b>M</b>				28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No				28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>00 3581</b>	
	29d. Date signed (Month, Day, Year) <b>4/25/96</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elliot R. Goldstein, M.D. 9410 Old Georgetown Rd., Bethesda, Maryland 20814</b>				31. Data filed (Month, Day, Year) <b>APR 26 1996</b>	
	32. Registrar's Signature 				33. State Registrar <b>APR 26 1996</b>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14627

Amended #1, 4/30/96, MRT, Montg. Cty **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>M. Gayle Cory</b>			2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>7:55 pm</b>												
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>			4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>												
Funeral Director	5. Social Security Number <b>007-30-8968</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 10, 1935</b>	9. Birthplace (State or Foreign Country) <b>Maine</b>											
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	10e. Street and Number <b>18825 South Meadow Fence Road</b>			10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>United States</b>												
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postmaster</b>		16b. Kind of Business/Industry <b>U. S. Senate Post Office</b>													
	17. Father's Name (First, Middle, Last) <b>George Fitzgerald</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Melissa Sturgeon</b>														
	19a. Informant's Name/Relationship (Type, Print) <b>Donald B. Cory</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>														
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>4-27-96</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>											
	21. Signature of Funeral Service Licensee <b>Eden H. Rapp</b>			22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>One Year</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>One Year</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death)	a. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>One Year</b>																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																	
	c. Due to (or as a consequence of):																	
	d. Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>																
		29c. License number <b>033686</b>		29d. Date signed (Month, Day, Year) <b>April 25, 1996</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kenneth Miller, MD 1811 Prince Philip Dr. Olney, MD 208</b>																		
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature <b>[Signature]</b>																

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14628

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Marion Cygan

2. Date of Death

April 30 1996

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

15713 Allnutt Lane

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

079-10-7589

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 26, 1917

9. Birthplace (State or Foreign Country)

Newton Falls, NY

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Burtonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15713 Allnutt Lane

10f. Zip Code

20866

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WW II  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Analyst

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Martin Cygan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wioncek

19a. Informant's Name/Relationship (Type, Print)

Mariann Cygan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15713 Allnutt Lane, Burtonsville, Maryland 20866

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Cyril Cemetery

Date

5/6/96

20c. Location - City or Town, State

Schenectady, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd. W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Heart Disease

Approximate Interval Between Onset and Death

Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO 8546

29d. Date signed (Month, Day, Year)

May 1 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Tauber M.D. 8218 Wisconsin Avenue #414, Bethesda, Maryland 20814-3107

31. Date filed (Month, Day, Year)

MAY 02 1996

32. Registrar's Signature

John F. Tauber

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14629

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES J. Cullen</b>		2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>0320</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>218-12-1258</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 30, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Somerset</b>
	10c. City, Town or Location <b>Crisfield</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>26500 Asbury Avenue</b>		10f. Zip Code <b>21817</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>H. S. Graduate</b> College (1-4 or 5+) <b>- - -</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>
	16b. Kind of Business/Industry <b>Insurance Agency</b>		17. Father's Name (First, Middle, Last) <b>E. King Sterling</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Geneva M. Byrd</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Chris Cullen (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26500 Asbury Avenue - Crisfield, MD 21817</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunnyridge Memorial Park-</b>		Date <b>5/4/96</b> 20c. Location - City or Town, State <b>Crisfield, MD</b>
	21. Signature of Funeral Service Licensee <b>Robert H. Bradshaw, Jr.</b>		22. Name and Address of Facility <b>Bradshaw &amp; Sons Funeral Home</b> <b>306 W. Main St. - Crisfield, MD 21817</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Cardiomyopathy</u></b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>		Approximate Interval Between Onset and Death <b>days</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatic Failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Jeffrey R. Hetherington, M.D.</b>		29c. License number <b>D36783</b>	
29d. Date signed (Month, Day, Year) <b>5/1/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey R. Hetherington, M.D. - Prince Georges MD 21811</b>			
31. Date filed (Month, Day, Year) <b>MAY 02 1996</b>		32. Registrar's Signature <b>John Bradshaw</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", certifier 23a must show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

③

**Abstract**



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State of Maryland / Department of Health and Mental Hygiene

96 14630

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John S. Chapman Jr</b>				2. Date of Death Month Day Year <b>Apr 30 1996</b>		3. Time of Death <b>1405</b>						
	4e. Facility Name (If not institution, give street and number) <b>Union Hospital</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>						
Funeral Director	5. Social Security Number <b>282-34-0712</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 30 1939</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>						
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Rising Sun</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No							
	10e. Street and Number <b>241 Bard Cameron Rd</b>			10f. Zip Code <b>21911</b>		10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1957</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Sporting Goods</b>							
	17. Father's Name (First, Middle, Last) <b>John S. Chapman Sr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Deditius</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>John S. Chapman VI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Frontier Dr 1200H Stanton VA 24401</b>								
	20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R A Ferris May 3 1996</b>		Date <b>May 3 1996</b>		20c. Location - City or Town, State <b>West Chester PA</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>R. T. Foard Funeral Home, P.A. 111 S Queen St Rising Sun MD 21911</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>ruptured abdominal aortic aneurysm</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>ongoing</b> </td> </tr> <tr> <td>b. <b>HTN</b></td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>ruptured abdominal aortic aneurysm</b>	Approximate Interval Between Onset and Death  <b>ongoing</b>	b. <b>HTN</b>	c.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>ruptured abdominal aortic aneurysm</b>	Approximate Interval Between Onset and Death  <b>ongoing</b>											
	b. <b>HTN</b>												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> <input checked="" type="checkbox"/> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)									
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number <b>D46882 MD</b>		29d. Date signed (Month, Day, Year) <b>4-30-1996</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Olabisi A Jagun., MD 106 Bow St. Elkton MD 21921</b>													
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

96 14631

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Ethel Carroll</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>1937</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>221-20-2107</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 29 1934</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>261 West Main Street</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Univ. of Delaware</b>		
	17. Father's Name (First, Middle, Last) <b>Walter Fisher</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Wengrewski</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>William H. Carroll</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>261 West Main Street, Elkton, MD. 21921</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Immaculate Conception Cem.</b>		Data <b>5/6/96</b>	20c. Location - City or Town, State <b>Cherry Hill, MD.</b>		
	21. Signature of Funeral Service Licensee <i>Donald S. Hicks</i>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 Day</b> <b>17 yrs.</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, Type II;</b> <b>ischemic Cardiomyopathy</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Monte Makous, MD</b>		29c. License number <b>0-44783</b>		29d. Date signed (Month, Day, Year) <b>5-3-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MONTA MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21921</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <i>John D. ...</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 14632

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Lee Clark</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>3:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>216-54-7815</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 19, 1949</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>720 Robinwood Drive</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Store Owner</b>			16b. Kind of Business/Industry <b>Music Store</b>	
17. Father's Name (First, Middle, Last) <b>Norman L. Grahl</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Janice E. O'Brien</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James E. Clark - Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 Robinwood Drive, Mt. Airy, Md. 21771</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pine Grove Cemetery 5/3/96</b>		20c. Location - City or Town, State <b>Mt. Airy, Md.</b>		
21. Signature of Funeral Service Licensee <b>Olin L. Molesworth</b>				22. Name and Address of Facility <b>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Small Cell Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>Eight months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Olin L. Molesworth</b>				29c. License number <b>033686</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Karen M. M. 18111 Pine Philip Dr. Olney, MD 20832</b>								
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>John A. ...</b>				

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14633

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles William COBLENTZ, SR.				2. DATE OF DEATH MONTH DAY YEAR April 24, 1996				3. TIME OF DEATH 1:10 P. M.	
4. SOCIAL SECURITY NUMBER 225-10-0404		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 14, 1903		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not Institution, give street and number) 411 Culler Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 411 Culler Avenue				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Refrigeration Engineer			16b. KIND OF BUSINESS/INDUSTRY Ice Company		
17. FATHER'S NAME (First, Middle, Last) Charles Herman Coblentz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Smith					
19a. INFORMANT'S NAME (Type/Print) Charles W. Coblentz, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Tenbury Road, Lutherville, MD 21093					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Mount Olivet Cemetery, April 27, 1996			20c. LOCATION — City or Town, State Frederick, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H. Ruby M00703				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerosis Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Heart Disease</i> <i>Stroke</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Francis E. Becker M.D.				29c. LICENSE NUMBER D30496 MD.				29d. DATE SIGNED (Month, Day, Year) 4/28/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Francis E. Becker, M.D., 300 West Ninth Street, Frederick, MD 21701									
31. DATE FILED (Month, Day, Year) APR 26 1996				32. REGISTRAR'S SIGNATURE John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

96-2384-033  
CIP

(per M.E.)

State of Maryland / Department of Health and Mental Hygiene

96 14634

Amended #26,5/13/96,PCT,Howard

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHRISTINA</b>				2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1996</b>				3. Time of Death <b>6:10AM</b>					
	4a. Facility Name (If not institution, give street and number) <b>12803 FERNWOOD TURN</b>				4b. City, Town, or Location of Death <b>LAUREL</b>				4c. County of Death <b>PRINCE GEORGES</b>					
Funeral Director	5. Social Security Number <b>25 7673</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>20</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>March 29, 1976</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>	
	Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Laurel</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>12803 Fernwood Turn</b>						10f. Zip Code <b>20708</b>				10g. Citizen of What Country? <b>U. S.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>none</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>none</b>				16b. Kind of Business/Industry <b>none</b>				
17. Father's Name (First, Middle, Last) <b>Andrew Jackson McNeal</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Cox</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Mary Burnett Mother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5318 5th Street, Zephyrhills, Florida 33541</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>				Date <b>May 6, 1996</b>		20c. Location - City or Town, State <b>Catonsville, Md</b>				
21. Signature of Funeral Service Licensed <i>[Signature]</i>						22. Name and Address of Facility <b>Donaldson Funeral Home 313 Talbott Avenue Laurel, Maryland</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CEREBRAL PALSY WITH COMPLICATIONS</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Geoup Home</b>										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Theodore M. King</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 4, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>														
31. Date filed (Month, Day, Year) <b>MAY 13 1996</b>				32. Registrar's Signature <i>[Signature]</i>										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

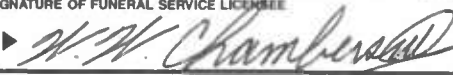
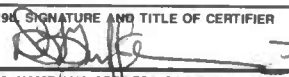

State  
Registrar



96 14635

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN H. DAVIS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>25</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>9:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-30-7835</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 23, 1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4500 SIGSBEE RD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4500 SIGSBEE RD.</b>			
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CARPENTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CARPENTRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES ADAM DAVIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE LEE McDANIEL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELIZABETH L. BLAKENEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>509 OLD PLANTATION DR., KINSTON, N.C. 28501</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		DATE <b>4/27</b>		20c. LOCATION — City or Town, State <b>RIVERDALE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0091</b>				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>MINUTES</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PERIPHERAL DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D42110</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 25, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D.L. GRIFFEN III 1525 SHADY GROVE ROAD ROCKVILLE MARYLAND 20850</b>							
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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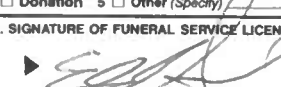

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96 14636

Amended #20b, 20c, MRT, 5/1/96, Montg. Cty.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joel Martin Deitch</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 30, 1996</b>				3. TIME OF DEATH <b>2:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-46-3534</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 29, 1937</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3817 Dunsinane Drive</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES, GIVE WAR OR DATES <b>1/26/1955 to 11/16/56</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Telemarketing</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Jessie Deitch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mark Deitch</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3817 Dunsinane Dr. Silver Spring MD 20906</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cheltenham Nat. Cemetery 5/2</b>		20c. LOCATION — City or Town, State <b>Cheltenham MD</b>		20d. LOCATION — City or Town, State <b>Upper Marlboro, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MD. Veterans Cem.</b>				22. NAME AND ADDRESS OF FACILITY <b>Edward Sagel Funeral Direction</b> <b>1091 Rockville Pike Rockville MD 20852</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LYMPHOMA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.								Approximate interval Between Onset and Death <b>6 WEEKS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL AND RESPIRATORY FAILURE</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Barry Hecht, M.D.</b>				29c. LICENSE NUMBER <b>019192</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARRY HECHT 3941 PERRANA DRIVE WHEATON, MD 20906</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 01 1996</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



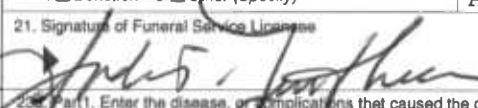

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14637

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH LEONARD DESSOFF</b>				2. Date of Death Month Day Year <b>April 23, 1996</b>		3. Time of Death <b>1:15 P.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>Largo Manor Care</b>				4b. City, Town, or Location of Death <b>Largo</b>		4c. County of Death <b>Prince George</b>	
Funeral Director	5. Social Security Number <b>579-03-3806</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 6, 1920</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>
	Usual Residence of Decedent							
10e. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>New Carrollton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7804 Powhatan Street</b>				10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plumbing Foreman</b>			16b. Kind of Business/Industry <b>The Defense Mapping Topographic Center</b>	
17. Father's Name (First, Middle, Last) <b>Alex Dessoff</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Weinberg</b>				
19e. Informant's Name/Relationship (Type, Print) <b>Pat Moore - Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7804 Powhatan Street, New Carrollton, Maryland 20784</b>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 5/7</b>		Date		20c. Location - City or Town, State <b>Arlington, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Carcinoma of Lung.</b> Several months Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Rakesh Arora, MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RAKESH ARORA, MD. 14300 GALLANT FOX LN #222 BOWIE MD 20715</b>								
31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14638

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BOUBAKAR

2. Date of Death

Month Day Year  
APRIL 23 1996

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

227-59-3017

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 25, 1938

9. Birthplace (State or Foreign Country)

Ivory Coast

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4615 North Park Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

Ivory Coast

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

18b. Kind of Business/Industry

GCA/World Bank

17. Father's Name (First, Middle, Last)

Fetegue Ouattara

18. Mother's Name (First, Middle, Maiden Surname)

Mariam Diaby

19a. Informant's Name/Relationship (Type, Print)

Constance Diaby-Ouattara/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4615 North Park Avenue, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of cemetery, crematory or other place)  
Municipal Cemetery  
of Samatiguila

Data

20c. Location - City or Town, State

Samatiguila,  
Ivory Coast, Africa

21. Signature of Funeral Service Licensee

Barbara Jo McMullen Lawrence M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PANCREATIC CARCINOMA

1/4 MONTHS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Victor Priego

29c. License number

023308

29d. Date signed (Month, Day, Year)

04/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR PRIEGO, M.D. 11420 ROCKVILLE PIKE #20 ROCKVILLE, MD. 20852

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

John Anderson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death, with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a-1 shows any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14639

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Francis R Drake</i>			2. Date of Death Month <i>April</i> Day <i>28</i> Year <i>1996</i>		3. Time of Death <i>11:40 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>4708 Howard Avenue</i>			4b. City, Town, or Location of Death <i>Beltsville</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>242-24-3850</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>December 19, 1917</i>
	9. Birthplace (State or Foreign Country) <i>North Carolina</i>						
Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Beltsville</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>4708 Howard Avenue</i>				10f. Zip Code <i>20705</i>		10g. Citizen of What Country? <i>United States</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>9</i> <i>College (1-4or 5+)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Domestic Engineer</i>	
17. Father's Name (First, Middle, Last) <i>Lemuel Rackley</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mamie Creekmore</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Richard Dexter Drake (son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>RD 1 Box 136R Lewes, Delaware 19958</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery</i>		Date <i>5/1/1996</i>		20c. Location - City or Town, State <i>Brentwood, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>				22. Name and Address of Facility <i>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Ischemic heart disease</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>August P. Rodriguez MD</i>				29c. License number <i>1021230</i>		29d. Date signed (Month, Day, Year) <i>April 28, 1996</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Hubert P. Rodriguez MD, 3009 Rayburn Cr. Cy Sp Md. 20748</i>							
31. Date filed (Month, Day, Year) <i>APR 30 1996</i>				32. Registrar's Signature <i>David R. ...</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" and items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14640

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ETHEL DUBOIS</b>				2. Date of Death Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>5:20 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>220-12-2516</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 4, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>14227 Grand Pre Road</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>Henry B. Banes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Muriel Hardy</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Helen M. Bryant</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14227 Grand Pre Road, Silver Spring, MD 20906</b>			
	20a. Method of Disposition <b>Burial of Ashes</b> <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Memorial Park</b>		20c. Location - City or Town, State <b>4/30/96 Falls Church, VA</b>		20d. Date	
	21. Signature of Funeral Service Licensee <i>Timothy J. Campbell</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Septicemia</b> Dua to (or as a consequence of): <b>b. Ischemia of Bowel</b> Dua to (or as a consequence of): <b>c.</b> Dua to (or as a consequence of): <b>d.</b>							
	Approximate Interval Between Onset and Death <b>24 Hours</b> <b>1 Year</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cachexia, Dementia</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Martin C. Shargel M.D.</i>								
29c. License number <b>D08944</b>								
29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Martin C. Shargel M. D. 3720 Farragut Avenue, Kensington, MD 20895</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>								
32. Registrar's Signature <i>Julia Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", for items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14641

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dale Edward Davis</b>				2. Date of Death Month Day Year <b>April 19, 1996</b>		3. Time of Death <b>5:10 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>42 Stayman Drive</b>				4b. City, Town, or Location of Death <b>Port Deposit</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>218-46-1613</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 30, 1947</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>MD</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Port Deposit</b>	
Usual Residence of Decedent		10e. Street and Number <b>42 Stayman Drive</b>		10f. Zip Code <b>21904</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Clerk</b>		16b. Kind of Business/Industry <b>Supermarket</b>				
17. Father's Name (First, Middle, Last) <b>Robert B. Davis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Bernadine Fallon Davis</b>				
19e. Informant's Name/Relationship (Type, Print) <b>Daughter</b> <b>Ms. Tina M. Liberatore,</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 306, Perry Point, Maryland 21902</b>				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		20c. Date <b>4/22</b>		20d. Location - City or Town, State <b>Aberdeen, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Carcinoma of Stomach</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>15 months</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				29c. License number <b>D-11115</b>		29d. Date signed (Month, Day, Year) <b>Apr. 19 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Neil Taylor Jr MD, PO 459 Rising Sun, MD 21911</b>								
31. Date filed (Month, Day, Year) <b>APR 19 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1945

1. The first part of the report is devoted to a description of the general situation in the country at the beginning of the year. It is noted that the economy is still in a state of depression, and that the government is struggling to maintain its financial position.

2. The second part of the report deals with the results of the various measures taken by the government to improve the economic situation. It is pointed out that these measures have had only a limited effect, and that the country is still facing serious difficulties.

3. The third part of the report discusses the prospects for the future. It is concluded that the country has a long way to go before it can achieve a stable and prosperous economy. It is recommended that the government should continue to implement the measures taken, and that it should also seek to attract foreign investment.

4. The fourth part of the report contains a summary of the main findings of the study. It is concluded that the country is still in a state of economic depression, and that the government is struggling to maintain its financial position. It is recommended that the government should continue to implement the measures taken, and that it should also seek to attract foreign investment.

3



96 14642

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Dunsen</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>22</b> YEAR <b>96</b>		3. TIME OF DEATH <b>6:40 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-28-9241</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5 31 31</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>V A MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>10 N GREEN ST</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>317 DAVIS RD STREET</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>DAVIS RD</b>				10f. ZIP CODE <b>21154</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>51 to 54</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School 11th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONCRETE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Matthew William Dunsen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nevada Geneva Edwards Dunsen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gina L Dunsen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9006 1 ROLL ST #2 LOS ANGELES CA 90006</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chestnut Chur Cemetery 4/22/96</b>		20c. LOCATION — City or Town, State <b>828 COEN RD MD</b>		22. NAME AND ADDRESS OF FACILITY <b>TITLE FUNERAL SERVICE 3836 OLD FEDERAL HWY JAR</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George W Little</b>				22. NAME AND ADDRESS OF FACILITY <b>TITLE FUNERAL SERVICE 3836 OLD FEDERAL HWY JAR</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>4 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MARK KAMINSKI MD</b>				29c. LICENSE NUMBER <b>6791</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARK KAMINSKI, MD 10 N. GREEN ST BALTIMORE MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>				32. REGISTRAR'S SIGNATURE <b>Johi Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14643

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Pearl Blansfield Dawson				2. DATE OF DEATH MONTH May 3 DAY 1996		3. TIME OF DEATH 0300	
4. SOCIAL SECURITY NUMBER 214-60-0917		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 19, 1913	
9a. FACILITY NAME (If not institution, give street and number) Medpointe Continuing Care Facility				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 345 Broad Street, Apartment No. 13				10f. ZIP CODE 21903		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Twelve Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Hughey Herbert Blansfield				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Ella Baker			
19a. INFORMANT'S NAME (Type/Print) David R. Dawson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 171 Craigtown Road, Port Deposit, Maryland 21904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Principio Cemetery		DATE 5/7/96		20c. LOCATION — City or Town, State Perryville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas M. Patterson, Sr.</i>				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Congestive Heart Failure</i>					
		b. <i>Coronary Artery Disease</i>					
		c.					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death <i>1 month</i> <i>2 years</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> <i>Parkinsonism</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sachdev</i>				29c. LICENSE NUMBER <i>DQ3322</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/3/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>S.S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 08 1996</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14644

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Iva M. Eppley

2. Date of Death

Month Day Year  
May 4 1996

3. Time of Death

7:00am

4a. Facility Name (If not institution, give street and number)

2660 Tome Highway

4b. City, Town, or Location of Death

Colora

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

206-38-9611

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 4 1892

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Colora

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

2660 Tome Hwy

10f. Zip Code

21917

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Herman DeVenney

18. Mother's Name (First, Middle, Maiden Surname)

Ida Strickler

19a. Informant's Name/Relationship (Type, Print)

Kathryn E. Forwood

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2660 Tome Hwy Colora MD 21917

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion May 7 1996

Date

20c. Location - City or Town, State

Allen Pennsylvania

21. Signature of Funeral Service Licensee

Robert A. Foad

22. Name and Address of Facility

R. T. Foad Funeral Home, P.A.  
111 S Queen St. Rising Sun MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonitis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

~10 years

c. Dementia

Due to (or as a consequence of):

~3 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Weidner MD

29c. License number

D44373

29d. Date signed (Month, Day, Year)

5/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Weidner, MD Colonial Way Rising Sun MD 21911

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



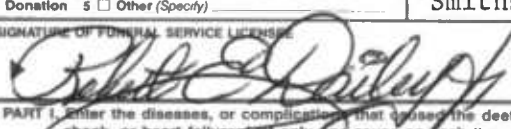

ITEM: 6. PER F.H. FILM G-736 6/6/96 t.t

96 14645

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALICE DARNER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 28, 1996</b>		3. TIME OF DEATH <b>8:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-32-0910</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 8, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Homewood Retirement Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Frederick</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>31 West Patrick Street</b>	
10f. ZIP CODE <b>21701</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>				16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph William Darner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Elizabeth Himes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kathleen D. Talbert</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1340 Taney Avenue Apt. #204 Frederick, MD 21702</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory 4/30</b>		20c. LOCATION — City or Town, State <b>Smithsburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Robert E. Dailey &amp; Son Funeral Homes, P.A. 1201 North Market St. Frederick, MD 21701</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Breast CANCER</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic DISEASE TO CHEST</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE Heart Failure</b>  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph Ashwal MD</b>				29c. LICENSE NUMBER <b>D26609</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-29-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph Ashwal, MD 56 Thomas Johnson Drive, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 30 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3



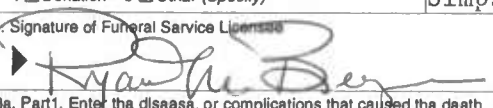
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14646

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGUERITE (NMN) DORSEY</b>				2. Date of Death Month Day Year <b>April 24, 1996</b>		3. Time of Death <b>10:33 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Northampton Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>217-28-5978</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 7, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>24 Sagner Dr.</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country?		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>self</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>housewife</b>		16b. Kind of Business/Industry <b>housewife</b>				
	17. Father's Name (First, Middle, Last) <b>Claman Crampton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Winifred Crampton</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Linda Ferguson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>202 Maple Ave., Frederick, MD 21701</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Simpson U.M. Church Cem.</b>		Date <b>4/30 1996</b>		20c. Location - City or Town, State <b>New Market, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>STAUFFER FUNERAL HOME 1621 Opossumtown Pike/ Frederick, Md. 21702</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>7/95</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D22214</b>		29d. Date signed (Month, Day, Year) <b>4/26/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Lloyd E. Halvorson 1475 Taney Ave./ Frederick, Maryland 21701</b>									
31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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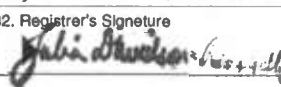
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14647

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FANNIE ELIZABETH DOVE</b>				2. Date of Death Month Day Year <b>April 21, 1996</b>		3. Time of Death <b>11:30 A.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-16-2306</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 17, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Ijamsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4702 Ijamsville Road</b>		10f. Zip Code <b>21754</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laundry Worker</b>		16b. Kind of Business/Industry <b>Frederick Mem Hospital</b>		17. Father's Name (First, Middle, Last) <b>George Crouse</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Alice Murphy</b>		19a. Informant's Name/Relationship (Type, Print) <b>Norma J. Renner, daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11433 Hill Road Keymar, Maryland 21757</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Linden Hills Cemetery</b>		20c. Date <b>4/24/96</b>		20d. Location - City or Town, State <b>Frederick, Maryland</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>e. CARIOmyopathy</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>9 YEARS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John A. Vitarello MD</b>		29c. License number <b>1027544</b>		29d. Date signed (Month, Day, Year) <b>4/22/98</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. John A. Vitarello, M.D. 310 West 9th Street Frederick, MD 21701</b>		31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death. If the death is a natural death, the Medical Examiner must be notified at once.

Important: If item 27 is marked other than "natural", for items 28 and 29, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 14648

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARTHUR FRANK ELZY</b>			2. Date of Death Month Day Year <b>APRIL 25 1996</b>		3. Time of Death <b>8:14P.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>WEST BOUND I-370</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>081-36-1858</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 29, 1945</b>		
	9. Birthplace (State or Foreign Country) <b>New York</b>								
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>19347 Circle Gate Drive</b>				10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1970-90</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 yrs</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Dunbar Armor Co.</b>			
17. Father's Name (First, Middle, Last) <b>Arthur Elzy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Lynch</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Kerensa Elzy (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4419 Saddle River Dr., Bowie, MD 20720</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat'l Cem. 5/16/96</b>		20c. Location - City or Town, State <b>Arlington, VA</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>4 25 96</b>		28b. Time of Injury <b>2012P M</b>		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>		28d. Describe how Injury occurred <b>EJECTED PASSENGER OF ARMORED CAR</b>					
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 370 + 355 Montgomery Co, MD</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>April 27, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYARITA KORELL MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



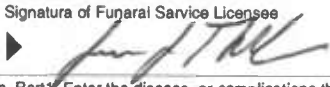
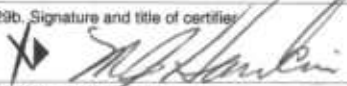
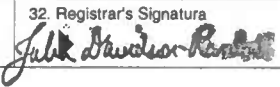
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14649

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Grady Elms</b>				2. Date of Death Month Day Year <b>April 23, 1996</b>				3. Time of Death <b>10:50 A.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>8324 Tuckerman Lane</b>				4b. City, Town, or Location of Death <b>Potomac</b>				4c. County of Death <b>Montgomery</b>						
Funeral Director	5. Social Security Number <b>455-10-6224</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 20, 1916</b>		9. Birthplace (State or Foreign Country) <b>Texas</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number <b>8324 Tuckerman Lane</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Officer</b>			16b. Kind of Business/Industry <b>C.I.A.</b>							
	17. Father's Name (First, Middle, Last) <b>Richard Elms</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unavailable</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>Susan Elms-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9119 Great Heron Circle, Orlando, FL 32836</b>										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Comfort Crematory</b>			Data <b>4/26/96</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons</b> <b>5130 Wisconsin Ave., N.W. Washington, D.C. 20016</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) <b>a. Malignant Melanoma</b> Dua to (or as a consequence of):  <b>b. </b> Dua to (or as a consequence of):  <b>c. </b> Dua to (or as a consequence of):  <b>d. </b> Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 years</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number <b>DC 19757</b>		29d. Date signed (Month, Day, Year) <b>4/24/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. Hawkins, M. D. 3800 Reservoir Road N.W. Washington, D. C. 20007</b>										31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14650

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susan Webb Effer

2. Date of Death

Month Day Year  
April 23, 1996

3. Time of Death

6:30am

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

578-20-0044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 22, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7812 Turning Creek Court

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Perpetual Building and Lion

17. Father's Name (First, Middle, Last)

Richard Webb

18. Mother's Name (First, Middle, Maiden Surname)

Alfretta Ault

19a. Informant's Name/Relationship (Type, Print)

Jerry Webb Effer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7812 Turning Creek Court, Potomac, MD 22854

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify):

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

4/25/96

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular accident

Approximate Interval Between Onset and Death

&gt;5yrs

Due to (or as a consequence of):

b. congestive Heart Failure

&gt;5yrs

Due to (or as a consequence of):

c. Hypertension

&gt;5yrs

Due to (or as a consequence of):

d. Anemia

&gt;5yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D35792

29d. Date signed (Month, Day, Year)

APRIL 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWAROOP G. RAO; 50 W. EDMONSTON DR, ROCKVILLE

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

3

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

96 14651

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT MCKINNNLEY EVANS</b> (AKA McKinney)			2. DATE OF DEATH MONTH <b>03</b> DAY <b>96</b> YEAR		3. TIME OF DEATH <b>4 42 P.M.</b>
4. SOCIAL SECURITY NUMBER <b>579-46-6418</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 29, 1907</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Home</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>La Plata</b>		9c. COUNTY OF DEATH <b>Charles</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Charles</b>	10c. CITY, TOWN OR LOCATION <b>Waldorf</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8503 Ridgeline Terrace</b>			10f. ZIP CODE <b>20603</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Printer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government-Commerce Dept</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Lee Evans</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Mae McKinney</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Florence B. Evans</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8503 Ridgeline Terrace, Waldorf, MD 20603</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens 5-7</b>		20c. LOCATION — City or Town, State <b>Waldorf, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn</b> M00053			22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home</b> <b>P. O. box 156, Waldorf, MD 20604</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>DEHYDRATION</b>					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
b. <b>ALZHEIMERS DISEASE</b>					
c. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>					
d. <b>FEW DAYS</b> <b>FEW MONTHS</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> NURSING HOME <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Ashvinkumar J. Patel, MD</b>			29c. LICENSE NUMBER <b>D-44436</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/3/96</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASHVINKUMAR J. PATEL, MD</b> <b>603 POST OFFICE RD # 807 WALDORF MD 20602</b>					
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE <b>Jubia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14652

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARCHIE SIDNEY EPSTEIN				2. DATE OF DEATH MONTH DAY YEAR APRIL 18, 1996		3. TIME OF DEATH 7:35 P M	
4. SOCIAL SECURITY NUMBER 577 - 18 - 6411		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	7. DATE OF BIRTH (Month, Day, Year) JULY 10, 1918		8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C.	
9a. FACILITY NAME (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CAMP SPRINGS		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Temple Hills		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2411 Oxon Run Drive				10f. ZIP CODE 20748		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Assistant		16b. KIND OF BUSINESS/INDUSTRY Veterans Administration			
17. FATHER'S NAME (First, Middle, Last) Harry Epstein				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Salor			
19a. INFORMANT'S NAME (Type/Print) Michael S. Epstein - Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13507 Old Annapolis Road, Mount Airy, Maryland 21771			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 5/1		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Williams</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UREMIA DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MULTI-ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth A. Ballou, MD</i>				29c. LICENSE NUMBER PA MD-057878-L		29d. DATE SIGNED (Month, Day, Year) APRIL 18, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENNETH A. BALLOU, CPT, USAF, MD 1050 WEST PERIMETER ROAD SUITE C1-7 ANDREWS AIR FORCE BASE, MD. 20762-6600							
31. DATE FILED (Month, Day, Year) APR 20 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14653

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAISA FELDMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 19, 1996</b>		3. TIME OF DEATH <b>3:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-29-4106</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC 22, 1899</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6105 MONTROSE ROAD</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NURSE</b>		18b. KIND OF BUSINESS/INDUSTRY <b>MEDICAL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>KHAKSEL KARELSHTEYN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>YEVGENIYA (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MICHAEL FELDMAN (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4708 BRADLEY BLVD #108, CHEVY CHASE, MD 20815</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHESED SHEL EMMES</b>		20c. DATE <b>4/21/96</b>		20d. LOCATION — City or Town, State <b>WASHINGTON, DC</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen E. Brosenne</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Alzheimer's dementia</b> b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Burt I. Feldman MD</i>				29c. LICENSE NUMBER <b>D23958</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/19/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Burt I. Feldman, MD, 6105 Montrose Rd., Rockville, MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Roth</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

D

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14654

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID William FESSENDEN</b>				2. Date of Death Month Day Year <b>APRIL 25 1996</b>		3. Time of Death <b>9-20 PM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>001-07-2216</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 27, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>New Hampshire</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Glen Echo</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>6005 Bryn Mawr Avenue</b>		10f. Zip Code <b>20812</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farm Labor Specialist</b>		16b. Kind of Business/Industry <b>U. S. Dept. of Labor</b>				
17. Father's Name (First, Middle, Last) <b>Walter B. Fessenden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Arabelle Prescott Bailey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>David W. Fessenden, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4901 Randolph Road, Rockville, MD 20852</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Data <b>4-27-96</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Dean H. Rapp</b>				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. GASTROINTESTINAL BLEEDING</b> Due to (or as a consequence of): <b>b. COLON CANCER</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE MYELOID LEUKEMIA</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. H. S. Chaudhry MD</b>				29c. License number <b>D-14364</b>		29d. Date signed (Month, Day, Year) <b>April 25 - 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mohammad H. CHAUDHRY MD. 7610 CARROLL AVE #300 TAKOMA PARK, MD 20912</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature <b>John Davidson-Rand</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Baltimore, Maryland 21215-0026  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14655

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMIL

FLAX

2. Date of Death

Month Day Year  
APRIL 28, 1996

3. Time of Death

4:45 PM

4a. Facility Name (If not institution, give street and number)

CIRCLE MANOR NURSING HOME

4b. City, Town, or Location of Death

KENSINGTON

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-05-5419

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 1, 1906

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

KENSINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10231 CARROLL PLACE

10f. Zip Code

20895

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

RESTAURANTEUR

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

NATHAN FLAX

18. Mother's Name (First, Middle, Maiden Surname)

ROSE JOLSON

19a. Informant's Name/Relationship (Type, Print)

MARTIN FLAX

(SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12800 ESWORTHY ROAD - N. POTOMAC, MARYLAND 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

KING DAVID MEMORIAL GARD. 4/30/96

Date

20c. Location - City or Town, State

FALLS CHURCH, VA.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.  
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPTICEMIA

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

Approximate Interval Between Onset and Death

WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE, CACHEXIA, ALZHEIMERS

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08944

29d. Date signed (Month, Day, Year)

APRIL 29, 1996

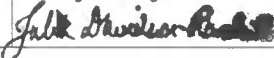
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARGEL, MD - 3720 FARRAGUT AVENUE - KENSINGTON, MD. 20895

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14656

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Randall L. Frazier				2. Date of Death Month Day Year May 2, 1996		3. Time of Death 4:30 PM		
	4a. Facility Name (If not institution, give street and number) 14810 Pettit Way				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 045-30-7722		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) July 9, 1940		
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 14810 Pettit Way		10f. Zip Code 20854		
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sr. Vice-Pres. of Finance				16b. Kind of Business/Industry Hotel Corporation				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Frazier				18. Mother's Name (First, Middle, Maiden Surname) Wayne Walion				
	19a. Informant's Name/Relationship (Type, Print) Sandra Y. Frazier				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 5-3-96 Beltsville, Maryland		
	21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PANCREATIC CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 YR.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of Certifier				
To Be Completed by Physician/Medical Examiner	29c. License number D 28656				29d. Date signed (Month, Day, Year) May 3, 1996				
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ravi Passi, M. D., 8609 2nd Avenue, #404B, Silver Spring, MD 20910				31. Date filed (Month, Day, Year) MAY 03 1996				
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature John Anderson				33. State Registrar				
	34. DHMH 16 Rev 6/95				35. Baltimore, Maryland 21215-0020				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

death within 72 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The Medical Examiner must be notified at any time 23a or 23b show any injury or other traumatic event. The Medical Examiner must be notified at any time 23a or 23b show any injury or other traumatic event.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14657

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARION M FYFE</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>				3. Time of Death <b>1:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>218-38-7992</b>		6. Sex <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>March 4, 1917</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Beltsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		10e. Street and Number <b>3207 Castleleigh Road</b>				10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>				18b. Kind of Business/Industry <b>Federal Government/ Health Care Industry</b>			
	17. Father's Name (First, Middle, Last) <b>Alexander McKenzie</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jane Forbes Davidson</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Craig A. Fyfe - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13820 Dayton Meadows Court, Dayton, Maryland 21036</b>					
	20a. Method of Disposition <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		Data <b>4-30</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MALIGNANT LYMPHOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>4 YEARS</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INSULIN DEPENDENT DIABETES MELLITUS</b>								23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No							
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D07285</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES A. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850</b>		31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 25a or 25b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

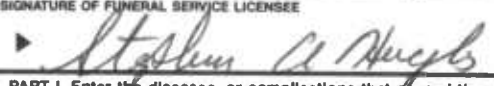
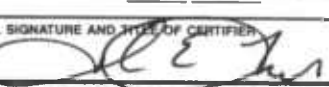
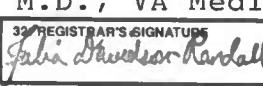


96 14658

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>DAVID FRANCIS FULMER</b>		2. DATE OF DEATH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>3:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>134-12-8363</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 30, 1918</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>		9. COUNTY OF DEATH <b>Cecil</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Perry Point VA Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Perry Point</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Joppa</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>418 Latimer Road</b>		10f. ZIP CODE <b>21085</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemical Engineer</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16. KIND OF BUSINESS/INDUSTRY <b>U. S. Government</b>		17. FATHER'S NAME (First, Middle, Last) <b>John Thomas Fulmer</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence (u/k) Bennett</b>		19a. INFORMANT'S NAME (Type/Print) <b>Josephine T. Fulmer</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>418 Latimer Road, Joppa, Md. 21085</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc. 5/1/96</b>		20c. LOCATION — City or Town, State <b>West Chester, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>End Stage Parkinson's Disease</b> DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):			
		c. DUE TO (OR AS A CONSEQUENCE OF):			
		d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D37065</b>	
29d. DATE SIGNED (Month, Day, Year) <b>4/28/96</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS FINUCAN, M.D., VA Medical Center, Perry Point, MD 21902</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 1 - 1996</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14659

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Velma Beatrice Finch			2. Date of Death May 4 1996 Year 8:35 AM		3. Time of Death 8:35 AM		
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital			4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles		
Funeral Director	5. Social Security Number 213-38-2698		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 25, 1915	
	9. Birthplace (State or Foreign Country) Alabama		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Charles 10c. City, Town or Location: La Plata 10d. Inside City Limits: 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4or 5+):		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
	17. Father's Name (First, Middle, Last) Emory S. Willingham		18. Mother's Name (First, Middle, Maiden Surname) Danie Jane Price		19. Informant's Name/Relationship (Type, Print) Carol F. Earnshaw		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10970 Earnshaw Lane, La Plata, MD 20646	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens 5-7		20c. Location - City or Town, State Waldorf, MD		21. Signature of Funeral Service Licensee Mark G. Brohawn M00053	
	22. Name and Address of Facility Huntt Funeral Home P.O. Box 156, Waldorf, MD 20604-0156		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Chronic Obstructive Pulmonary Disease years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier B. L. Jenkins		29c. License number D33426		29d. Date signed (Month, Day, Year) 5/4/96	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) B. Larry Jenkins, MD 111 LaGrange Ave P.O. Box 1724 LaPlata, MD 20646		31. Date filed (Month, Day, Year) MAY 07 1996		32. Registrar's Signature Julia Davidson Randall			
	33. Date of Death (Month, Day, Year) MAY 04 1996		34. Registrar's Signature Julia Davidson Randall		35. Date of Death (Month, Day, Year) MAY 04 1996			

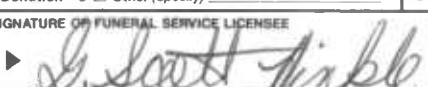
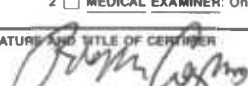


96 14660

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Orpha Kirk Fike				2. DATE OF DEATH MONTH DAY YEAR 05 09 96		3. TIME OF DEATH 9:10 PM	
4. SOCIAL SECURITY NUMBER 232-42-6623		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-04-1905	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE WV.		10b. COUNTY Preston		10c. CITY, TOWN OR LOCATION Eglon		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 44				10f. ZIP CODE 26716		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) David W. Kirk				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Annon Kirk			
19a. INFORMANT'S NAME (Type/Print) Adrian Martin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 Las Cruces Crt. Lady Lake, Fla. 32159			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Grove Cemetery 5/12/96		20c. LOCATION — City or Town, State Grafton, WV.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV. 26260			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Intracranial Hemorrhage					Approximate Interval Between Onset and Death 20 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Cerebral Artery Disease					Years
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D33464		29d. DATE SIGNED (Month, Day, Year) MAY 17 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Coughlin, MD, P. O. Box 8, Eglon, WV 26716							
31. DATE FILED (Month, Day, Year) MAY 17 1996							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14661

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAROLD LEON GRAY</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>11:07 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>217-30-7044</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 1, 1934</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince Georges</b> 10c. City, Town or Location <b>Aquasco</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>19611 Aquasco Road</b>		10f. Zip Code <b>20608</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Date: <b>July 26, 1956 - July 16, 1958</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Automotive</b>		17. Father's Name (First, Middle, Last) <b>James Cardinal Gray</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Ellen Bond Gray</b>				19. Informant's Name/Relationship (Type, Print) <b>Lillian Makle - Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15231 Makle-Hayden Place Brandywine, Maryland 20613</b>		20. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
21. Signature of Funeral Service Licensee <b>Lloyd M. Estep</b>				22. Name and Address of Facility <b>Adams Funeral Home Aquasco, Maryland</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Generalized Atherosclerotic Cardio-Vascular Disease</b>		Approximate Interval Between Onset and Death <b>years</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>J. Berger MD</b>		29c. License number <b>D25925</b>		29d. Date signed (Month, Day, Year) <b>May 1, 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. BERGER MD #205, 7720 WISCONSIN AVE, Bethesda, MD 20814</b>				31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14662

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORA Lee

2. Date of Death

MAY

Day

1996

3. Time of Death

2:20 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-42-4524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul 19, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Brookeville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19812 Zion Rd,

10f. Zip Code

20833

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

Collega (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Louis Webster

18. Mother's Name (First, Middle, Maiden Surname)

Maude Swailes

19a. Informant's Name/Relationship (Type, Print)

William W. Gaither (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19812 Zion Rd, Brookeville, Md 20833

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt Zion Church Cem.

Date

5/4

20c. Location - City or Town, State

Brookeville, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850  
Rockville, Md23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute cardiopulmonary arrest

Due to (or as a consequence of):

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Bilateral cerebrovascular accident

Due to (or as a consequence of):

8 days

c. Hypertensive cardiovascular disease

Due to (or as a consequence of):

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

massive obesity

Brookeville medical

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)

May 1, 1996

28b. Time of  
Injury

2:20 PM

28c. Injury et  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

DO 4421

29d. Date signed (Month, Day, Year)

May 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBEN C. COSCA, M.D. 17529 REPCAND ROAD, DEERWOOD, MD 20855

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14663

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis F. Galeano				2. Date of Death Month Day Year April 29, 1996				3. Time of Death 9:38 PM	
	4e. Facility Name (If not institution, give street and number) 702 Brantford Ave				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-07-7219		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Feb 27, 1919		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 702 Brantford Ave				10f. Zip Code 20904		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946 1966		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Tax Firm			
	17. Father's Name (First, Middle, Last) Joseph Galeano				18. Mother's Name (First, Middle, Maiden Surname) Jennie Lozupone					
	19e. Informant's Name/Relationship (Type, Print) Catherine G. Amberg/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Stateside Dr, Silver Spring, MD 20904					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date May 13		20c. Location - City or Town, State Arlington, VA			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cirrhosis of Liver</u> Due to (or as a consequence of): b. <u>Hepatocellular Carcinoma</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic renal insufficiency</u>									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number P08546		29d. Date signed (Month, Day, Year) May 2 96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Tauber 8218 Wisconsin Ave, Bethesda, MD 20814									
31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20



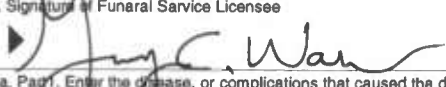

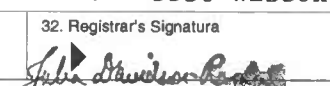
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14664

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eunice B. Given</b>				2. Date of Death Month <b>April</b> 26, Day <b>26</b> , Year <b>1996</b>		3. Time of Death <b>7:00 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care - Fernwood</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>224-32-9237</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>4-9-1906</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>6530 Democracy Boulevard</b>		10f. Zip Code <b>20817</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Nursing</b>	
	17. Father's Name (First, Middle, Last) <b>Charles D. Brewer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martha D. Foster</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lee Brewer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>201 Front Street #203 Key West, Florida 33040</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Memorial Park</b>		20c. Location - City or Town, State <b>4/29/96 Falls Church, Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Bowel Obstruction</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 				29c. License number <b>D39456</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lila T. McConnell, M. D. 5530 Wisconsin Ave. Chevy Chase, MD 20815-4401</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0000


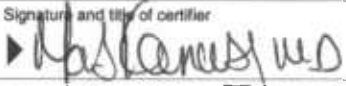
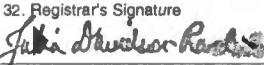
Division of Vital Records, P.O. Box 68760,

3

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14665

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Benjamin GOLDEN</b>				2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>11:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>579-68-2707</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1906</b>	9. Birthplace (State or Foreign Country) <b>Russia</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5225 Pooks Hill Rd. #1604N</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Doctor</b>			16b. Kind of Business/Industry <b>Medical</b>	
17. Father's Name (First, Middle, Last) <b>Edwin Golden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sima Blanken</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Soma Golden Behr/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5225 Pooks Hill Rd. #1604N, Bethesda, MD 20814</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Comfort Cemetery</b>		Date <b>4/26</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Edward Sagel Funeral Direction, Rockville, MD</b>				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Polycytemia Vera</b> <b>Peripheral vascular disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D292229</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>5530 Wisconsin Ave. #1443 Chevy Chase MD 20815 Martin S. Kanarsky</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar





96 14666

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George E. Goodreau, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 29, 1996		3. TIME OF DEATH 5:07A. M	
4. SOCIAL SECURITY NUMBER 363-10-8362		5. SEX XX M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 27, 1915	
8. BIRTHPLACE (State or Foreign Country) Michigan		9a. FACILITY NAME (If not institution, give street and number) 4006 Harrison Road		9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4006 Harrison Road				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Latent Finger Print Expert		16b. KIND OF BUSINESS/INDUSTRY Federal Bureau of Investigation			
17. FATHER'S NAME (First, Middle, Last) George E. Goodreau, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura LaRochelle			
19a. INFORMANT'S NAME (Type/Print) Lois Carolyn Goodreau				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/30/1996		20c. LOCATION — City or Town, State Alexandria, Virginia		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. CARDIOMYOPATHY Due to (or as a consequence of): c. CORONARY ARTERY DISEASE AND Due to (or as a consequence of): d. MITRAL VALVE DISEASE. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE AIRWAY DISEASE MILD RENAL INSUFFICIENCY							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH XX Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Asif S. Qadri				29c. LICENSE NUMBER D22910		29d. DATE SIGNED (Month, Day, Year) April 29, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Asif S. Qadri, M.D. 4700 Berwyn House Road, #100 College Park, Maryland 20740							
31. DATE FILED (Month, Day, Year) APR 30 1996				32. REGISTRAR'S SIGNATURE Julia Anderson-Rand			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14667

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Felix Alberto Gracia

2. Date of Death

Month April 29, Day 1996 Year

3. Time of Death

11:25 A.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-66-6057

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
Sept. 16, 1946

9. Birthplace (State or Foreign Country)

Colombia

Usual Residence of Decedent

10a. State

none

10b. County

none

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

35 E. St., N.W.

10f. Zip Code

20001

10g. Citizen of What Country?

Colombia

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Colombian14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

waiter

16b. Kind of Business/Industry

food service

17. Father's Name (First, Middle, Last)

Felix Gracia

18. Mother's Name (First, Middle, Maiden Surname)

Clara Jimenez

19a. Informant's Name/Relationship (Type, Print)

Jairo A. Gracia/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

378 Prospect Blvd., Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

May 2, 96

20c. Location - City or Town, State

Alex., Virginia

21. Signature of Funeral Service Licensee

John F. DeVol

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W., Wash., D.C. 20007

23a. Print. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Massive stroke  
Due to (or as a consequence of):b. Shock  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Christopher Unger

29c. License number

D 15929

29d. Date signed (Month, Day, Year)

APRIL 29, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christopher Unger, M.D., 8218 Wisconsin Ave., Bethesda, Md. 20814-3169

31. Date filed (Month, Day, Year)

MAY 12 1996

32. Registrar's Signature

John F. DeVol

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 28 is marked other than "natural",  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14668

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martin L. Greenberg				2. Date of Death Month Day Year April 26 1996				3. Time of Death 4:59 pm	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 182-03-6401		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 12, 1915		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2504 Dawson Ave.				10f. Zip Code 20902		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Florist			16b. Kind of Business/Industry Owner		
	17. Father's Name (First, Middle, Last) Phillip Greenberg				18. Mother's Name (First, Middle, Maiden Surname) Esther Schwartz					
	19a. Informant's Name/Relationship (Type, Print) Lillian Greenberg (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Dawson Ave. Wheaton, Maryland 20902					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Menorah Gardens		20c. Location - City or Town, State 4-28-96 Rockville, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike-Rockville, Md. 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Acute Anterior Myocardial Infarction Due to (or as a consequence of):  b. Coronary Artery Disease Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Physician /Medical Examiner	23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D21334		29d. Date signed (Month, Day, Year) 4/27/96			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Daniel Goldberg 10401 Old Georgetown Rd Bethesda, MD 20814									
State Registrar	31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 14669

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACOB ALFRED GILES, JR.</b>				2. Date of Death Month <b>APRIL</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>12:42 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>219-28-9056</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 15, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>602 Edmund Street</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance worker</b>		16b. Kind of Business/Industry <b>U.S. Post Office</b>				
17. Father's Name (First, Middle, Last) <b>Jacob A. Giles, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Warfield</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jacob A. Giles, III</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 Edmund St., Aberdeen, Maryland 21001</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Berkley Memorial Cemetery</b>		20c. Date <b>5/1/96</b>		20d. Location - City or Town, State <b>Darlington, MD</b>		
21. Signature of Funeral Service Licensee <b>Hersken Amy Unglesbee</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>METASTATIC RECTAL CANCER</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Joan P. Edwards, M.D.</b>		29c. License number <b>D31775</b>		29d. Date signed (Month, Day, Year) <b>APRIL 26, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOAN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047</b>								
31. Date filed (Month, Day, Year) <b>APR 27 1996</b>								
32. Registrar's Signature <b>John A. ...</b>								

Baltimore, Maryland 21215-0026

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. It is a very important document, as it contains the President's annual message to Congress. The letter is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a report from the Secretary of the Interior, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a report from the Secretary of the Treasury, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

4. The fourth part of the document is a report from the Secretary of the War, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

6. The sixth part of the document is a report from the Secretary of the Army, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

7. The seventh part of the document is a report from the Secretary of the State, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.

8. The eighth part of the document is a report from the Secretary of the War, dated January 3, 1862. It is a very important document, as it contains the Secretary's annual report to the President. The report is written in a very formal and dignified style, and it is one of the most important documents in the history of the United States.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14670

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ROBERTA ELLEN GIFFORD</b>						2. Date of Death Month Day Year <b>APRIL 26 1996</b>		3. Time of Death <b>8:00 PM</b>	
4a. Facility Name (If not Institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>TOWSON MD.</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>333-14-7999</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 16, 1922</b>		9. Birthplace (State or Foreign Country) <b>Missouri</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>634 Harborside Drive</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Robert Bernard Winter</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Louise Dawdy</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Dennis C. Gifford - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>628 Falconbridge Dr., Joppa, Md. 21085</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Company</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>W. Chester, Pa.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LEFT LOWER LOBE PNEUMONIA</b> Due to (or as a consequence of): <b>b. EMPHYSEMA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death <b>2 WEEKS</b>  <b>YEARS</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>  <b>ADENOCARCINOMA OF RECTUM</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  <b>Joginder P Mehta, M.D.</b>				29c. License number <b>D41410</b>		29d. Date signed (Month, Day, Year) <b>April 26th, 96.</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOGINDER MEHTA M.D. ST. JOSEPH MEDICAL CENTER, TOWSON, MARYLAND 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 1 - 1996</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1.

1. The first part of the report is a general  
description of the project and its objectives.  
It is followed by a detailed description of the  
methodology used in the study.

3

The results of the study are presented in the  
third part of the report. They are followed by  
a discussion of the findings and their implications.  
The report concludes with a summary of the  
main findings and a list of references.


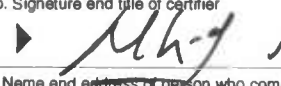
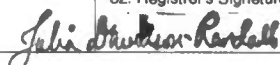
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14671

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lola Goldsborough</b>				2. Date of Death Month Day Year <b>May 2 1996</b>		3. Time of Death <b>5:15 P.M.</b>						
	4e. Facility Name (If not institution, give street and number) <b>Calvert Manor Healthcare Center</b>				4b. City, Town, or Location of Death <b>Calvert</b>		4c. County of Death <b>Cecil</b>						
Funeral Director	5. Social Security Number <b>222-12-4663</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 18 1905</b>						
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>						
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6 Stoney Chase Drive</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry									
17. Father's Name (First, Middle, Last) <b>John Chadwick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Garrett</b>									
19e. Informant's Name/Relationship (Type, Print) <b>Elizabeth K. Johnson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Stoney Chase Drive, Elkton, MD. 21921</b>									
20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co.</b>		20c. Location - City or Town, State <b>West Chester, PA.</b>		20d. Date <b>5-4-96</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, MD. 21921</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Myocardial Infarction</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>1 hour</b>   <b>6 months</b> </td> </tr> <tr> <td>b. <b>Congestive Heart Failure</b></td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Myocardial Infarction</b>	Approximate Interval Between Onset and Death  <b>1 hour</b>  <b>6 months</b>	b. <b>Congestive Heart Failure</b>	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Myocardial Infarction</b>	Approximate Interval Between Onset and Death  <b>1 hour</b>  <b>6 months</b>											
	b. <b>Congestive Heart Failure</b>												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebro Vascular Disease</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>047211</b>		29d. Date signed (Month, Day, Year) <b>May 6, 1996</b>							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVID GAR-EL M.D. 3 Mauldin Ave North East, md 21901</b>													
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 2058.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14672

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wojoech Frank Gransky

2. Date of Death

Month Day Year

3. Time of Death

5 5 96 1130 am

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

215-30-2973

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

April 13, 1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1524 Ingleside Avenue

10f. Zip Code

21903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Eight Years

College (1-4 or 5+)

-----

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chief of Land Maintenance

Post Engineers

16b. Kind of Business/Industry

Aberdeen Proving Ground

Aberdeen, Maryland

17. Father's Name (First, Middle, Last)

Joseph Gransky

18. Mother's Name (First, Middle, Maiden Surname)

Anna Wszolek

19a. Informant's Name/Relationship (Type, Print)

Lucile R. Gransky

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1524 Ingleside Avenue, Perryville, Maryland 21903

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Mark's Cemetery

Date

5/9/96

20c. Location - City or Town, State

Perryville, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson &amp; Son Funeral Home

Perryville, Maryland 21903

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

3 Days

b. Intracerebral Hemorrhage

Due to (or as a consequence of):

20 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Neurosurgeon

29c. License number

6614

29d. Date signed (Month, Day, Year)

5/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Doherty, MD 22 Sorensen St, Balto, MD 21201

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

Julia Brubaker Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 14673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edna Greenwalt				2. DATE OF DEATH MONTH DAY YEAR May 1, 1996				3. TIME OF DEATH 6:00 A M			
4. SOCIAL SECURITY NUMBER 236-46-1477		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 16, 1926		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 18810 Sandy Hook Road				9b. CITY, TOWN OR LOCATION OF DEATH Knoxville				9c. COUNTY OF DEATH Washington			
10a. STATE Maryland				10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Knoxville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 18810 Sandy Hook Road				10f. ZIP CODE 21758			
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6			
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Homemaker				17. FATHER'S NAME (First, Middle, Last) Harry Jacob Ashbaugh			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Marie Bengers				19a. INFORMANT'S NAME (Type/Print) Patricia Weaver - Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18816 Sandy Hook Road - Knoxville, MD 21758			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer Cemetery 5/4				20c. LOCATION — City or Town, State Loudoun Heights, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. Spencer				22. NAME AND ADDRESS OF FACILITY Eackles-Spencer Funeral Home Harpers Ferry, WV 25425				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER J. L. Henry MD				29c. LICENSE NUMBER D35553				29d. DATE SIGNED (Month, Day, Year) 5/2/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. L. Henry 610 9th Ave. Brunswick MD 21716				31. DATE FILED (Month, Day, Year) MAY 02 1996				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be retained by the funeral director. Page 4 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14674

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rose Frances GIEHL</b>				2. Date of Death Month Day Year <b>April 30, 1996</b>		3. Time of Death <b>0800</b>								
	4e. Facility Name (If not institution, give street and number) <b>Saint Catherine's Nursing Home</b>				4b. City, Town, or Location of Death <b>Emmitsburg</b>		4c. County of Death <b>Frederick</b>								
Funeral Director	5. Social Security Number <b>152-10-3682</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 21, 1919</b>								
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>								
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>7097 Catalpa Road</b>		10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Anthony Fryga</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Blacha</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Andrea Giehl-Whitney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Saint Lisa's Place, Stafford, Virginia 22554</b>											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>May 3, 1996</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>									
21. Signature of Funeral Service Licensee <i>Richard C.C. Basford</i>		22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b> <b>106 East Church Street, Frederick, Md. 21701</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Subarachnoid Hemorrhage with</b> Due to (or as a consequence of): <b>Persistent Coma</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>2 mo</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Lung Disease</b> <b>Atherosclerotic Heart Disease</b> <b>Hypertension</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Alan L. Carroll</i>		29c. License number <b>018205</b>		29d. Date signed (Month, Day, Year) <b>5/1/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan L. Carroll, M.D., 310 South Seton Avenue, Emmitsburg, Maryland 21727</b>		31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <i>John Davidson-Randall</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



96 14675

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ethel Della GRAY</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>20</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:00 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>240-32-8880</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 9, 1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>300 North Place</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Switchboard operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Mark A. Baisey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sue Clark</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Reba B. Miller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 Sandstone Drive, Walkersville, Md. 21793</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens April 23, 1996 Frederick, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Allan H Ruby M00703</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Old cerebrovascular accident</b> <b>Brightest Vascular disease</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Arthur G. Manalo</b>				29c. LICENSE NUMBER <b>D18191</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-22-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arthur G. Manalo, M.D., 187 Thomas Johnson Drive, Frederick, Md. 21702</b>							
31. DATE FILED (Month, Day, Year) <b>APR 23 1996</b>		32. REGISTRAR'S SIGNATURE <b>Davidson Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14676

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARSON NMN GIBSON				2. Date of Death Month Day Year April 17, 1996		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) 13142 Old National Pike				4b. City, Town, or Location of Death Mt. Airy		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-30-2060		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) March 28, 1933	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mt. Airy	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13142 Old National Pike		10f. Zip Code 21771		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck driver		16b. Kind of Business/Industry Bus/ Transportation				
17. Father's Name (First, Middle, Last) Waymon Gibson		18. Mother's Name (First, Middle, Maiden Surname) Ethel Collins		19. Informant's Name/Relationship (Type, Print) Randy S. Gibson/ SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8526 Discovery Blvd. Walkersville, MD 21793		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Garden		20c. Date 4/20/96		20d. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. CORONARY ARTERY DISEASE Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate interval between Onset and Death YEARS						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number H 39804		29d. Date signed (Month, Day, Year) April 19, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Summers, David, M.D. 915 Tollhouse Avenue, Frederick, Maryland 21701		31. Date filed (Month, Day, Year) APR 20 1996		32. Registrar's Signature [Signature]				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 14677

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Clifford Galloway</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>2</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>6:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>527-14-0142</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 23, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Nevada</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Mallard Bay Center-Genesis</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>	
9c. COUNTY OF DEATH <b>Dorchester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Dorchester</b>	
10c. CITY, TOWN OR LOCATION <b>Cambridge</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4231 Bestpitch Ferry Road</b>	
10f. ZIP CODE <b>21613</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Military Colonel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Felix Ethelbert Galloway</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Christian Hansen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Constance D. Galloway-spouse</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>MD 21613 4231 Bestpitch Ferry Rd., Cambridge</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Cambridge Crematory 5-3</b>		20c. LOCATION — City or Town, State <b>Cambridge, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Curran</i> <b>MO0125</b>				22. NAME AND ADDRESS OF FACILITY <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>2 day</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dehydration</b> <b>chronic alcoholism</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edmund J. MacLaughlin MD</i>				29c. LICENSE NUMBER <b>P-28209</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 2, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edmund J. MacLaughlin 4 Aurora St Cambridge, Md 21613</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 6 - 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






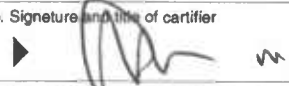
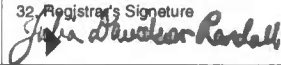
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14678

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillie Caroline Harris</b>				2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>				3. Time of Death <b>11:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Long View Nursing Home</b>				4b. City, Town, or Location of Death <b>Manchester</b>				4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>217-24-1308</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Jan 5, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Finksburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1439 Wesley Road</b>		10f. Zip Code <b>21048</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Presser</b>	
	16b. Kind of Business/Industry <b>Websters Clothing</b>		17. Father's Name (First, Middle, Last) <b>Daniel Rill</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ellen Zepp</b>		19. Informant's Name/Relationship (Type, Print) <b>Dorothy Blizzard</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>940 Emory Church Rd. Upperco, MD 21155</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hampstead Cemetery</b>		Date <b>5/8</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St., Hampstead, Md 21074</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>1 month</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D33165</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Steven Shaffer no 2111 Harrow Pike Hampstead md 21074</b>	
	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14679

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN MARY HYNES

2. Date of Death

Month Day Year

MAY 1 1996

3. Time of Death

1035

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

220-46-5366

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr 12, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Ohio

10b. County

10c. City, Town or Location

Cornersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Tippyicanoe Road

10f. Zip Code

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Clerk

16b. Kind of Business/Industry

Bob's Variety

17. Father's Name (First, Middle, Last)

William Stout

18. Mother's Name (First, Middle, Maiden Surname)

Annabelle Elher

19a. Informant's Name/Relationship (Type, Print)

Adelaide M. Klingenberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1900 Springhill Lane, Hampstead, MD 21074

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremations

Date

5/3

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Steve W. Eline

22. Name and Address of Facility

Eline Funeral Home

934 S. Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ASPIRATION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA, COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi MD

29c. License number

D37333

29d. Date signed (Month, Day, Year)

MAY 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI MD, NHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

David S. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14680

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Inez Hassett

2. Date of Death  
Month Day Year  
April 23, 19963. Time of Death  
10:30 A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9504 Edgeley Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

069-03-5325

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 10, 1904

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9504 Edgeley Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Electrical Contracting

17. Father's Name (First, Middle, Last)

Albert Austin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Burns

19a. Informant's Name/Relationship (Type, Print)

Joanne M. O'Donnell / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9504 Edgeley Road, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

4/26/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

De Vol Funeral Home

10 E. Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Cerebral Infarct

4 days

Due to (or as a consequence of):

b. Cerebral Arterial Occlusion

4 days

Due to (or as a consequence of):

c. Cerebral Atherosclerosis

20 years

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Heart Disease

Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-02047

29d. Date signed (Month, Day, Year)

April 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph D. Connor, M.D., 9420 Old Georgetown Road, Bethesda, Maryland 20814-1729

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

John D. Connor

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14681

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George C. Hescoc</b>				2. Date of Death Month Day Year <b>April 26 1996</b>				3. Time of Death <b>6:00 A.M.</b>		
	4e. Facility Name (If not institution, give street and number) <b>7319 Maple Avenue</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>001-36-3032</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 15, 1947</b>		9. Birthplace (State or Foreign Country) <b>New Hampshire</b>		
	Usual Residence of Decedent										
10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>7319 Maple Avenue</b>				10f. Zip Code <b>20815</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive Vice President</b>			16b. Kind of Business/Industry <b>Trade Association</b>				
17. Father's Name (First, Middle, Last) <b>George C. Hescoc, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Jones</b>						
19e. Informant's Name/Relationship (Type, Print) <b>Charlene Hescoc</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7319 Maple Avenue Chevy Chase, Maryland 20815</b>						
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Date <b>4/30/96</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Myocardial Infarction</b> Due to (or as a consequence of):  b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____										Approximate Interval Between Onset and Death  <b>1 Day</b>  <b>10 Years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number <b>MD D09522</b>			29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Richard Scheonfeld M.D. 5530 Wisconsin Avenue Suite 1445 Chevy Chase, MD 20815</b>											
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

item #2, filing 736, 6/14/96, cyw, per LR.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14682

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Junior Carl Hill

2. Date of Death April 28,  
Month Day Year  
April 29, 19963. Time of Death  
3:15 PM

4a. Facility Name (If not institution, give street and number)

1410 Morningside Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

062-20-8439

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 21, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1410 Morningside Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1947-194913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Heavy Equipment Engineer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Harold A. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Florence M. Shaw

19a. Informant's Name/Relationship (Type, Print)

Eva Mae Hill / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1410 Morningside Drive, Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

5/2/96

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Director

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 sec

b. Prostate Cancer

Due to (or as a consequence of):

2 yrs

c. Anemia

Due to (or as a consequence of):

6 months

d. Renal Failure

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 39190

29d. Date signed (Month, Day, Year)

MAY 1, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

John Davidson

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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96 14683

DHHM 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician  
/Medical  
Examiner

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>ANNE R. HOUDEK</b>		2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>755 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Medbridge Medical &amp; Rehabilitation Center</b>			4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>524-82-8566</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1934</b>	
9. Birthplace (State or Foreign Country) <b>Minnesota</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	
10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1005 South Kenwood Street</b>	
10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>United States</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookseller</b>		16b. Kind of Business/Industry <b>Book Store</b>	
17. Father's Name (First, Middle, Last) <b>LeRoy Houdek</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Prihoda</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Kanani L. Kauka</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>908 Prospect Street, #1, Takoma Park, MD 20912</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>4-30-96 Beltsville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LUNG CANCER</b> Due to (or as a consequence of): <b>BONE METASTASIS</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>BONE METASTASIS</b> Due to (or as a consequence of): <b>LUNG CANCER</b>					Approximate Interval Between Onset and Death <b>1 YR</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D 31650</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN GUTHEIL, 22 S. GREENE ST., BALTO, MD 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 02 1996</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14684

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Mary Patricia Hughes				2. Date of Death Month Day Year April 21, 1996		3. Time of Death 11:24 AM	
4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
5. Social Security Number 336-18-9560		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) May 17, 1923	
9. Birthplace (State or Foreign Country) Illinois		10a. State None		10b. County None		10c. City, Town or Location Washington, D.C.	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2000 Connecticut Avenue, NW #813		10f. Zip Code 20008		10g. Citizen of What Country? United States	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry United States Department of State			
17. Father's Name (First, Middle, Last) William Hughes				18. Mother's Name (First, Middle, Maiden Surname) Margaret McDonald			
19a. Informant's Name/Relationship (Type, Print) Bernadette McKeown/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12411 S. Natchez Ave., Palos Heights, IL 60463			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Sepulchre Cemetery		20c. Location - City or Town, State Worth, Illinois		20d. Date April 27, 1996	
21. Signature of Funeral Service Licensee Rory Faulk M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Chronic Obstructive Pulmonary Disease</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <u>1 week</u>  <u>long-standing</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>metastatic Breast Cancer</u>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Paul H. H. M.D.		29c. License number 221435		29d. Date signed (Month, Day, Year) April 22, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul H. H. M.D. 2101 Medical Park Dr Silver Spring MD 20902							
31. Date filed (Month, Day, Year) APR 29 1996		32. Registrar's Signature John Davidson-Rodriguez					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14685

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MURIEL HURWITZ</b>				2. Date of Death Month Day Year <b>APRIL 29, 1996</b>				3. Time of Death <b>10:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LAYHILL CENTER - GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>015-30-3774</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F <b>XX</b>		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 9, 1912</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>	
	Usual Residence of Decedent				10e. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>4306 BEL PRE ROAD</b>				10f. Zip Code <b>20853</b>	
	10g. Citizen of What Country? <b>UNITED STATES</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>				16b. Kind of Business/Industry <b>OWN HOME</b>				17. Father's Name (First, Middle, Last) <b>ABRAM PARKER</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>ISABEL ANTHONY</b>				19a. Informant's Name/Relationship (Type, Print) <b>BETTY GOLDMAN (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4306 BEL PRE ROAD - ROCKVILLE, MARYLAND 20853</b>	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TEMPLE BETH-EL CEM.</b>				20c. Location - City or Town, State <b>5/1/96 PEABODY, MASSACHUSETTS</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>				23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cerebrovascular Accident</b>	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>1D18726</b>				29d. Date signed (Month, Day, Year) <b>APRIL 30, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ARTHUR SCHUENGOLOD, M.D. 18111 Prince Philip Dr, OLNEY, MD 20832</b>				31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14686

## - Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Commodore Marshall Hanks</b>			2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1996</b>			3. Time of Death <b>12:17pm</b>											
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>			4b. City, Town, or Location of Death <b>Fallston</b>			4c. County of Death <b>Harford</b>											
Funeral Director	5. Social Security Number <b>233-34-9175</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 30, 1918</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Street</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>1008 Heaps Road</b>				10f. Zip Code <b>21154</b>		10g. Citizen of What Country? <b>USA</b>											
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>			16b. Kind of Business/Industry <b>Food</b>										
	17. Father's Name (First, Middle, Last) <b>William Samuel Hanks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie (nmn) Smith</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Hanks, son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC68, Box 928A, Hanover, West Virginia 24839</b>													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Highview Memorial Gardens</b>			Date <b>5/1/96</b>		20c. Location - City or Town, State <b>Fallston, Maryland</b>									
	21. Signature of Funeral Service Licensee <b>Holley K. McComas</b>				22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Diabetes Mellitus Type II</b></td> <td>Approximate Interval Between Onset and Death <b>8/93</b></td> </tr> <tr> <td>b. <b>Myocardial Infarction</b></td> <td><b>8/93</b></td> </tr> <tr> <td>c. <b>Aortic Stenosis</b></td> <td><b>8/93</b></td> </tr> <tr> <td>d. <b>Slow Sino Sinus Syndrome</b></td> <td><b>2/92</b></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>Diabetes Mellitus Type II</b>	Approximate Interval Between Onset and Death <b>8/93</b>	b. <b>Myocardial Infarction</b>	<b>8/93</b>	c. <b>Aortic Stenosis</b>	<b>8/93</b>	d. <b>Slow Sino Sinus Syndrome</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>Diabetes Mellitus Type II</b>	Approximate Interval Between Onset and Death <b>8/93</b>																
	b. <b>Myocardial Infarction</b>	<b>8/93</b>																
	c. <b>Aortic Stenosis</b>	<b>8/93</b>																
	d. <b>Slow Sino Sinus Syndrome</b>	<b>2/92</b>																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? <b>NA</b>																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																		
28a. Date of Injury (Month, Day Year) <b>NA</b>			28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <b>Stephen H. Sheldrake</b>					29c. License number <b>H40583</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>2013 Ste 114 Kamm Rd Bel Air Md 21015</b>																		
31. Date filed (Month, Day, Year) <b>1-1996</b>																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14687

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gideon Overton Harne Jr.					2. Date of Death Month Day Year April 21 1996		3. Time of Death 8:40 PM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital					4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 214-10-1110		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 11, 1913		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 605 Lee Place				10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collage (1-4or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier			16b. Kind of Business/Industry US Postal Service		
	17. Father's Name (First, Middle, Last) Gideon Overton HARNE, SR.					18. Mother's Name (First, Middle, Maiden Surname) Alta REDMOND				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Ellen Claudine Harne, Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Lee Place, Frederick, Maryland 21702				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, April 25, 1996			Data		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard E. Draf M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church Street, Frederick, Md. 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. AMYLOIDOSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 4 weeks YEARS									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LUA, Pneumonitis, Atrial Fibrillation. Coronary artery disease, Chronic Obstructive Pulmonary disease									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28t. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier MD				29c. License number D 18063		29d. Date signed (Month, Day, Year) 4/22/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Abdul Majeed MD 801 Toll House Avenue, Frederick, Maryland 21701									
31. Date filed (Month, Day, Year) APR 23 1996			32. Registrar's Signature John Davidson Randall							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14688

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sigmund Stanley Hartz			2. Date of Death Month Day Year April 22 1996		3. Time of Death 2:16 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 216-16-3097	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 15, 1923	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 104 Mercer Court			10f. Zip Code 21701		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14-or 5+) 1		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hartz Clothing Company		16b. Kind of Business/Industry self/ clothing		
	17. Father's Name (First, Middle, Last) Benjamin Hartz			18. Mother's Name (First, Middle, Maiden Summa) Cecelia Fox			
	19a. Informant's Name/Relationship (Type, Print) Natalie M. Hartz/ WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Mercer Court, Frederick, Maryland 21701			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 4/23/96	20c. Location - City or Town, State Hagerstown, Maryland	
	21. Signature of Funeral Service Licensee <i>Raymond Pata</i>			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIAC - ARRHYTHMIA</u> Due to (or as a consequence of): b. <u>CARDIO MYOPATHY</u> Due to (or as a consequence of): c. <u>HYPERTENSION</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death MINUTES YEARS YEARS						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PNEUMONIA</u> <u>LEUKOPENIA / THROMBOCYTOPENIA</u> <u>END STAGE RENAL DISEASE</u>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>William H. Johnson M.D.</i>			29c. License number D47556		29d. Date signed (Month, Day, Year) 4/22/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WILLIAM H. JOHNSON, MD 56 THOMAS JOHNSON DRIVE, FREDERICK MD 21702						
	31. Date filed (Month, Day, Year) APR 23 1996			32. Registrar's Signature <i>John Davidson Randolph</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 14689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNIE C. HYDE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>19</b> YEAR <b>96</b>		3. TIME OF DEATH <b>8:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>579-38-5916</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 30, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Kensington</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3000 McComas Ave.</b>	
10f. ZIP CODE <b>20895</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Key Punch Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Insurance Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William C. Craver</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Mae Lare</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patsy Z. Reece</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28721 Ridge Road, Mt. Airy, Md. 21771</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn 4/24/96</b>		20c. LOCATION - City or Town, State <b>Rockville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Olin L. Molesworth</i>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Gastrointestinal Bleeding</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. ...</i>				29c. LICENSE NUMBER <b>208546</b>		29d. DATE SIGNED (Month, Day, Year) <b>APR 11 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John T. ... 8218 Wisconsin Ave</b>							
31. DATE FILED (Month, Day, Year) <b>APR 20 1996</b>				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3



96 14690

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD LEE HARGROVE</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>30</b> YEAR <b>96</b>		3. TIME OF DEATH <b>12:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>165-16-1974</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/27/20</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1258 Ocean Parkway</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Berlin</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1258 Ocean Parkway</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Motel Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Richard D. Hargrove</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Bailey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edna Hargrove</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8004 Ocean Pines Berlin, MD 21811</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 5/13/96</b>		20c. LOCATION — City or Town, State <b>Arlington, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Burbage Funeral Home 108 Williams St. Berlin, MD 21811</b>			
23. PART I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stiphan Dan</i> MD				29c. LICENSE NUMBER <b>D41721</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. PAVLOS 560 RIVERSIDE DR SALISBURY MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14691

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT ALBAUGH HULL

2. Date of Death

MAY 6, 1996

3. Time of Death

8AM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

217-36-3185

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 19, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

735 Warfieldsburg Road

10f. Zip Code

21157

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Lewis Edwin Hull

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Florence Albaugh

19a. Informant's Name/Relationship (Type, Print)

Edwin E. Hull, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

516 Hook Road, Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Krider's Church Cemetery

Date

5/9/96

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

Katherine Pitter - Sweitzer

22. Name and Address of Facility

Pitts Funeral Home & Chapel  
412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schreyer MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

MAY 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DANIT SCHREYER, MD 200 MEMORIAL AVENUE WESTMINSTER, MARYLAND

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

John Paulsen-Rodall

21157

State  
Registrar

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or "items 27a and 27b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14692

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alma Jackson				2. Date of Death Month Day Year April 30 1996				3. Time of Death 9:27 AM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-36-5458		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) 3/18/40		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1016 Hollywood Avenue				10f. Zip Code 20904		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) deli manager			16b. Kind of Business/Industry supermarket		
	17. Father's Name (First, Middle, Last) James H. Williams				18. Mother's Name (First, Middle, Maiden Surname) Bessie Sexton					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert C. Jackson, husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Hollywood Avenue Silver Spring, MD 20904					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		20c. Location - City or Town, State 5/2/96 Mt. Airy, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD 20904					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast cancer Due to (or as a consequence of): b. Cerebrovascular accident Due to (or as a consequence of): c. Breast cancer Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 mo 1 yr 7 yrs									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D35996				29d. Date signed (Month, Day, Year) 05-01-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Dr #201, Silver Spring, MD 20902									
31. Date filed (Month, Day, Year) MAY 03 1996		32. Registrar's Signature 								



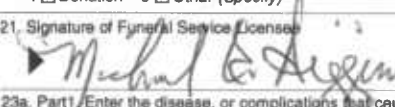
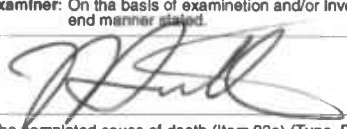
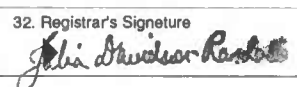
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14693

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marian Bradford Jasch</b>				2. Date of Death Month Day Year <b>April 24, 1996</b>				3. Time of Death <b>9:37 PM</b>										
	4a. Facility Name (If not institution, give street and number) <b>4808 Moorland Lane #703</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>										
Funeral Director	5. Social Security Number <b>578-34-2349</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 8, 1926</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>										
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>4808 Moorland Lane #703</b>				10f. Zip Code <b>20814-6139</b>		10g. Citizen of What Country? <b>Montgomery</b>												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>United States Government</b>												
	17. Father's Name (First, Middle, Last) <b>Henry C. Bradford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marian Lester</b>														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Wendy P. Jasch/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4808 Moorland Lane #703, Bethesda, Maryland 20814-6139</b>														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>May 7, 1996</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>										
	21. Signature of Funeral Service Licensee  <b>M00846</b>				22. Name and Address of Facility <b>Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             e. <b>Metastatic Ovarian Cancer</b>            Due to (or as a consequence of):             b. Due to (or as a consequence of):             c. Due to (or as a consequence of):             d.         </td> <td colspan="9">           1 Year         </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  e. <b>Metastatic Ovarian Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	1 Year							
Immediate Cause (Final disease or condition resulting in death)  e. <b>Metastatic Ovarian Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	1 Year																		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
	29b. Signature and title of certifier 				29c. License number <b>D22086</b>		29d. Date signed (Month, Day, Year) <b>April 25, 1996</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick P. Smith, M.D., 5401 Western Avenue, N.W., Washington, D.C. 20015-2998</b>																			
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", contents 23a or 28a-f show any injury or other traumatic event the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various expeditions and the collections made. The second part of the report deals with the results of the various expeditions and the collections made. The third part of the report deals with the results of the various expeditions and the collections made.

3

2. The second part of the report deals with the results of the various expeditions and the collections made. It also mentions the results of the various expeditions and the collections made. The third part of the report deals with the results of the various expeditions and the collections made. The fourth part of the report deals with the results of the various expeditions and the collections made.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14694

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charmesha Jolani Erwin Johnson

2. Date of Death

Month Day Year  
April 26, 1996

3. Time of Death

4:24 AM

4e. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

32

8. Date of Birth

(Month, Day, Year)  
April 26, 1996

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

5053 Berwyn Road

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

None

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Charles Earl Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Jennifer Ann Marie Mitchell

19e. Informant's Name/Relationship (Type, Print)

Charles &amp; Jennifer Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other facility)

Chesapeake Crematory

Date

5-1-96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

▶ *Elean H Rapp*

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Extreme Prematurity*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Huyoung B...*

29c. License number

H 45952

29d. Date signed (Month, Day, Year)

3/27/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

626604 J DOWNING, DO PhD, Holy Cross Hospital Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 02 1996 ▶ *Julia Harrison-R...*State  
RegistrarBaltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



ible. 14695

## Certificate of Death

Reg. No.

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", of items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14696

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Mae Jacobs				2. Date of Death Month Day Year May 1, 1996		3. Time of Death 5:42 pm		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 213-16-1647		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 6, 1920	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 501 Linden Avenue				10f. Zip Code 20703		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collegia (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Teller		16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) Samuel D. Crone				18. Mother's Name (First, Middle, Maiden Surname) Leanna Main				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lee M. Jacobs				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Linden Avenue, Frederick, Md. 21703				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium, or other place) Mt. Olivet Cemetery		Data May 4, 1996		20c. Location - City or Town, State Frederick, Md. 21701		
	21. Signature of Funeral Service Licensee Richard C.C. Basford 00021				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Acute Pericardial Tamponade Due to (or as a consequence of): b. Aortic dissection Due to (or as a consequence of): c. Atherosclerosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 20 min. 2 1/2 hours years								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of injury N/A M		28c. Injury at Work? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred N/A	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier M. H. MD		29c. License number D47397		29d. Date signed (Month, Day, Year) 5/1/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael W. Levangie, MD 310 W. 9th St. Frederick, MD 21701									
31. Date filed (Month, Day, Year) MAY 03 1996			32. Registrar's Signature John Anderson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Everett William Jones				2. Date of Death Month April Day 21, Year 1996		3. Time of Death 3:50AM		
	4a. Facility Name (If not Institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 219-54-5029		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Mar 24 1936		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State MD 10b. County Frederick 10c. City, Town or Location Knoxville 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Street and Number 3518 Olive School Road		12. Zip Code 21758		
13. Citizen of What Country? USA		14. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		15. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		16. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		17. Race - American Indian, Black, White, etc. Specify: White	
18. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12		19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Extrauden Op/Security GD		20. Kind of Business/Industry Master Detective Shenandoah Plastics		21. Father's Name (First, Middle, Last) Everett Thomas Jones		22. Mother's Name (First, Middle, Maiden Summe) Many Edwina Minn	
23. Informant's Name/Relationship (Type, Print) Margaret A. Jones		24. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3518 Olive School Rd., Knoxville, MD 21758		25. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		26. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive Cemetery 4/24/96		27. Location - City or Town, State Maugansville MD	
28. Signature of Funeral Service Licensee Barbara A. Williams, Owner		29. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Rd, Brunswick, MD 21716		30. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of): b. Insulin dependent diabetes mellitus Due to (or as a consequence of): c. Chronic obstructive Pulmonary Disease Due to (or as a consequence of): d. Morbid Obesity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		31. Approximate Interval Between Onset and Death		32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure, Left Lower Lobe Pneumonia, Diabetic Gastroparesis, Maxillary Sinusitis	
33. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		34. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		35. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		36. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		37. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
38. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		39. Date of Injury (Month, Day, Year)		40. Time of Injury M		41. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		42. Describe how Injury occurred	
43. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		44. Location (Street and Number or Rural Route Number, City or Town, State)		45. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		46. Signature and title of certifier		47. License number D-37178	
48. Date signed (Month, Day, Year) 4-21-96		49. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Christopher Fleming MD 610 Ninth Ave, Brunswick, Md. 21716		50. Date filed (Month, Day, Year) APR 26 1996		51. Registrar's Signature John Davidson-Randall		52. State Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


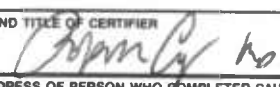
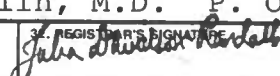




96 14698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Barbara Jean Jones</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>13</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>01:32 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>233-52-0625</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05/02/1933</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Garrett County Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV.</b>		10b. COUNTY <b>Tucker</b>		10c. CITY, TOWN OR LOCATION <b>Davis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. Box 493</b>				10f. ZIP CODE <b>26260</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Music Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Elementary &amp; Secondary Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Glen Norman, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bess Rosenmerkel</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert L. Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 493 Davis, WV. 26260</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV. 26260</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>4 Hours</b> <b>Years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D33464</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 13, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert M. Coughlin, M.D. P. O. Box 8, Eglon, WV 26716</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 17 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD REFERENCE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14699

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Sophia Jones				2. Date of Death Month Day Year MAY 02 1996		3. Time of Death 0500A						
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester						
Funeral Director	5. Social Security Number 220-10-6074		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 11, 1915	9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number 533 Cedar Street				10f. Zip Code 21613		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur		16b. Kind of Business/Industry Restaurant						
	17. Father's Name (First, Middle, Last) Garfield Chester				18. Mother's Name (First, Middle, Maiden Surname) Amelia Henson								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gloria Bell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1542 Lochwood Rd Baltimore, Maryland 21218								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithfield Cemetery		Data 5/8/96		20c. Location - City or Town, State Taylors Island, MD						
	21. Signature of Funeral Service Licensee <i>Jamelle C. Henry</i>				22. Name and Address of Facility Henry Funeral Home 510 Washington St. Cambridge, MD 21613								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <i>Pneumonia</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <i>6 days</i>   <i>years</i> </td> </tr> <tr> <td>b. <i>Chronic obstructive pulmonary disease</i></td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Pneumonia</i>	Approximate Interval Between Onset and Death  <i>6 days</i>  <i>years</i>	b. <i>Chronic obstructive pulmonary disease</i>	c.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Pneumonia</i>	Approximate Interval Between Onset and Death  <i>6 days</i>  <i>years</i>											
	b. <i>Chronic obstructive pulmonary disease</i>												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus, Congestive heart failure</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred									
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>David G. Oliver</i>											
		29c. License number 039749		29d. Date signed (Month, Day, Year) 5/2/96									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David G Oliver 503 Duthers Lane Ector MD 21601													
31. Date filed (Month, Day, Year) MAY 6 1996		32. Registrar's Signature <i>Johanna Randall</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14700

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Wilson Kerere, Sr.</b>				2. Date of Death Month <b>4</b> Day <b>24</b> Year <b>96</b>		3. Time of Death <b>11:58 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>236-44-9588</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 28, 1933</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3520 Weller Road</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Classified</b>		16b. Kind of Business/Industry <b>Department of Defense</b>			
	17. Father's Name (First, Middle, Last) <b>Mike Kerere</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Martino</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary R. Kerere</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3520 Weller Road, Silver Spring, Maryland 20906</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>4/29/96</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
	21. Signature of Funeral Service Licensee <i>Andrew J. Cole</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 20901 500 University Boulevard West, Silver Spring, MD</b>			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Hypertension - severe</b> Due to (or as a consequence of): <b>c. Diabetes Mellitus Type II</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>24 hours</b>
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Michael R. Dohardse</i>				29c. License number <b>D01138</b>		29d. Date signed (Month, Day, Year) <b>4-25-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael R. Dohardse 13975 Connecticut Ave Silver Spring MD 20906</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature <i>John D. ...</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14701

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

IDA KILMAN

2. Date of Death

Month

Day

Year

APRIL 26, 1996

3. Time of Death

752 AM

4a. Facility Name (If not Institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-33-8628

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 15, 1910

9. Birthplace (State or Foreign Country)

Rashkov Moldova

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

273 N. Van Buren St.

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Fivel Schwartz

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19. Informant's Name/Relationship (Type, Print)

Iosif Rabinovich

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Dundee Rd Rockville MD 20850

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens 4/29

Date

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18726

29d. Date signed (Month, Day, Year)

April 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR SCHWENGLER MD 9715 MEDICAL CENTER DR, ROCKVILLE, MD.

State  
Registrar

31. Date filed (Month, Day, Year)

APR 30 1996

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

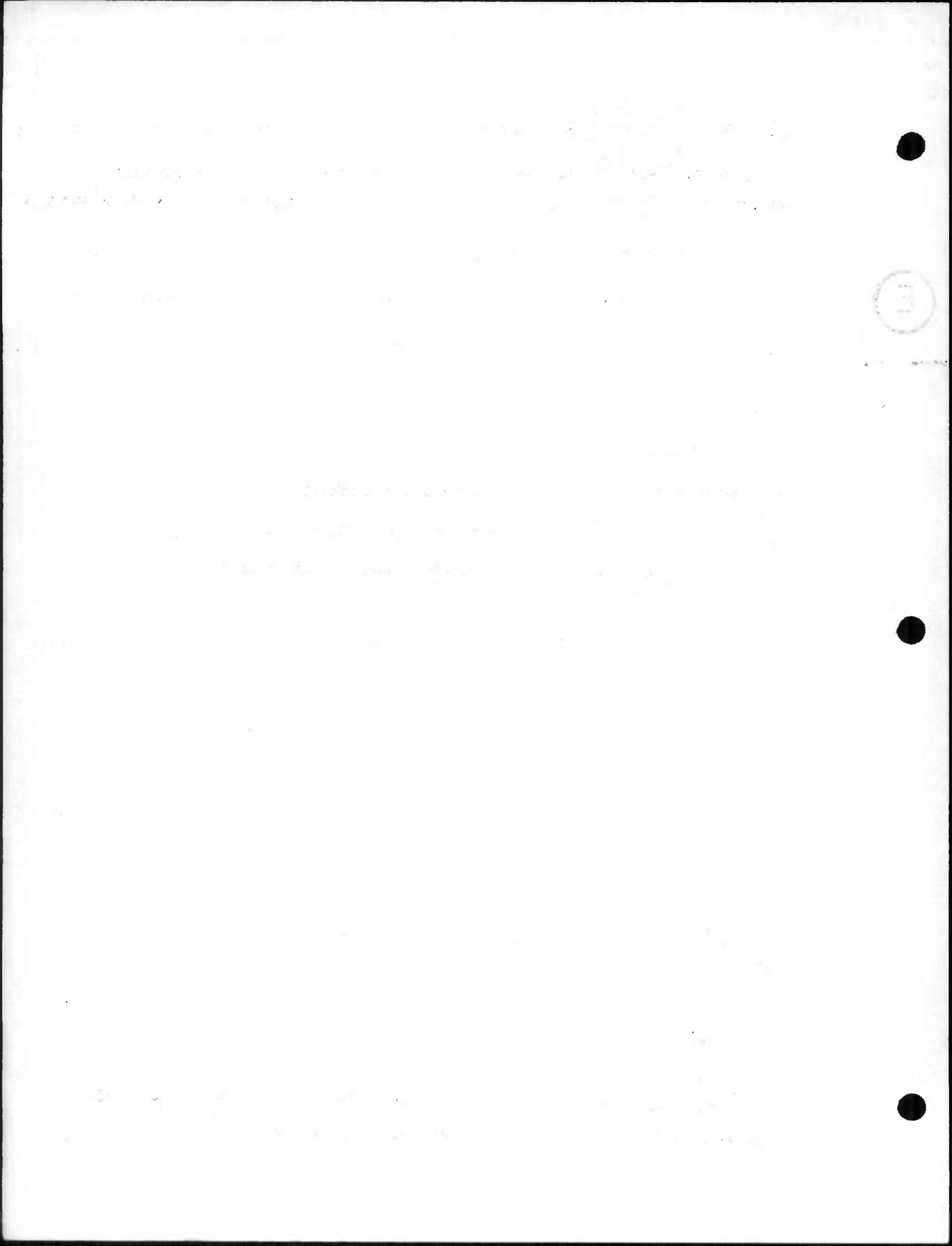
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14702

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth R. Kittridge				2. Date of Death Month Day Year April 25, 1996				3. Time of Death 6:05PM	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 190-16-3204		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 27, 1923		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Pennsylvania		10b. County Washington		10c. City, Town or Location McMurray				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 94 Center Church Road				10f. Zip Code 15317		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Joseph Di Matteo				18. Mother's Name (First, Middle, Maiden Surname) Mary Morelli					
	19a. Informant's Name/Relationship (Type, Print) F. William Kittridge/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Center Church Road, McMurray, Pennsylvania 15317					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Queen of Heaven Cemetery			20c. Location - City or Town, State Washington, Pennsylvania		
	21. Signature of Funeral Service Licensee <i>Michael P. Kittridge</i> MO0348				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>CARDIO PULMONARY ARREST</i> Due to (or as a consequence of): b. <i>CORONARY ARTERY DISEASE</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 4 days 2 years									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypoxia Encephalopathy</i>									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>Carl I. Schoenberger MD</i>				29c. License number D 26520		29d. Date signed (Month, Day, Year) APRIL 25 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Carl I. Schoenberger MD 16220 Frederick Rd. Gaithersburg, MD</i>									
31. Date filed (Month, Day, Year) APR 29 1996										
32. Registrar's Signature <i>Julia Davidson</i>										

Baltimore, Maryland 21215-0029

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

Page 1 of 1

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14703

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Austin

Klinger, JR

2. Date of Death  
Month Day Year

April 28 1996

3. Time of Death

1240pm

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

214-24-9332

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 13, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1406 Thornden Road

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1945-195413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Operating Engineer

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Charles Austin Klinger, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Florence Edna Grimm

19a. Informant's Name/Relationship (Type, Print)

Joyce I. Klinger/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1406 Thornden Road, Rockville, Maryland 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

May 2, 1996

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Raymond

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Ventricular fibrillation

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

sec

min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

Thai McQuinn MD

29c. License number

D47093

29d. Date signed (Month, Day, Year)

April 28, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shady Grove Emergency Department

9901 Medical Center Dr. Rockville

MD 20850

31. Date filed (Month, Day, Year)

MAY 01 1996

32. Registrar's Signature

Shady Grove

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 14704

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KARL KLOMPARENS</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>30</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>6:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>364-20-1235</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 7, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>13520 Cleveland Drive</b>				10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesperson</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Processing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Klomparsens</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margarite Gilmore</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Stephen H. Klomparsens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13520 Cleveland Drive, Rockville, Maryland 20850</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		DATE <b>May 2, 1996</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Rory Jank</b> M00198				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc.</b> <b>300 West Montgomery Avenue</b> <b>Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebral Thrombosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Cerebral Arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>2 Wks</b> <b>5 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James R. Moore Jr. MD</b>				29c. LICENSE NUMBER <b>07231</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James R. Moore Jr. 207 Brookes Ave Gaithersburg MD 20877</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>		32. REGISTRAR'S SIGNATURE <b>John A. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

Amended 4/30/96 Block #7 BEF/FCHD

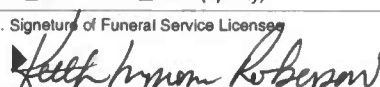
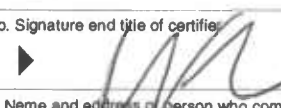
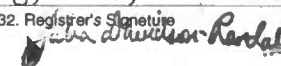
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14705

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marguerite Ruth KOCH</b>				2. Date of Death Month Day Year <b>April 26, 1996</b>		3. Time of Death <b>12:18 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>4635 Newington Road</b>				4b. City, Town, or Location of Death <b>Jefferson</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>145-12-9707</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 14, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Jefferson</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>4635 Newington Road</b>				10f. Zip Code <b>21755</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Charles CALLAGHAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marguerite THEEG</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Carl M. Koch/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4635 Newington Road, Jefferson, Maryland 21755</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		Date <b>Apr 29, 1996</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
	21. Signature of Funeral Service Licensee  <b>MO0706</b>		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Metastatic Cancer of Liver</b> Due to (or as a consequence of): b. <b>Adenocarcinoma (Unknown Primary)</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>days</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>D37178</b>		29d. Date signed (Month, Day, Year) <b>April 26, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Christopher Fleming, M.D., 610 Ninth Avenue, Brunswick, Maryland 21716</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1





96 14706

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sarah Isabelle</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>26</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>8:00 am M</b>	
4. SOCIAL SECURITY NUMBER <b>213-50-7747</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 20, 1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6811 Buckingham Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Buckeystown</b>				9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Buckeystown</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6811 Buckingham Lane</b>				10f. ZIP CODE <b>21717</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William KABRICK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella FISHER</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Alan M. Hunter, Jr., Grandson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6811 Buckingham Lane, Box 53, Buckeystown, Md. 21717</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Mount Olivet Cemetery, April 29, 1996</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard E. Hrap</b> MO0255				22. NAME AND ADDRESS OF FACILITY <b>Keeney &amp; Basford P.A. Funeral Home 106 E Church St. Frederick, MD 21701</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>late stage dementia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>cachexia</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Between Onset and Death <b>&gt; 7 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>pernicious anemia, decubitus, contractures / bedridden status</b>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Susan Brinkley</b>				29c. LICENSE NUMBER <b>D43389</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 26, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Susan Brinkley, M.D., 915 Tollhouse Avenue, Suite 203, Frederick, Maryland 21701</b>									
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

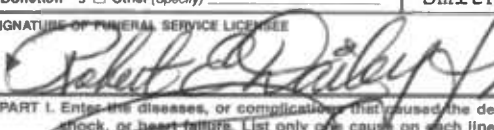
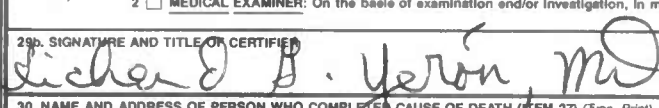
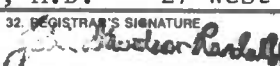
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14707

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STEWART KENNEDY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 25, 1996</b>		3. TIME OF DEATH <b>0620 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>137-32-3570</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 29, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MISSOURI</b>		10b. COUNTY <b>Platte</b>		10c. CITY, TOWN OR LOCATION <b>Parkville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>30 Mill Street</b>				10f. ZIP CODE <b>64152</b>		10g. CITIZEN OF WHAT COUNTRY? <b>J.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Kennedy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susan Mary Withers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Maureen K. Ridge</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1761 Stonehaven Lane Frederick, Md. 21702</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		DATE <b>4/26</b>		20c. LOCATION — City or Town, State <b>Smithsburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 N. Markt St. Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COLON CANCER</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>yr</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>041717</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 25, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type Print) <b>Richard G. Yeron, M.D. 27 West 7th Street Frederick, Md. 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14708

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Nathaniel Kinna

2. Date of Death

Month 4 Day 23 Year 96

3. Time of Death

7:55 PM

4a. Facility Name (If not institution, give street and number)

1233 Rosemont Drive

4b. City, Town, or Location of Death

Knoxville

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

215-14-2623

6. Sex

M 2 F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6/7/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Knoxville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1233 Rosemont Drive

10f. Zip Code

21758

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Brakeman

16b. Kind of Business/Industry

B&amp;O Railroad

17. Father's Name (First, Middle, Last)

David Ina Kinna

18. Mother's Name (First, Middle, Maiden Surname)

Bessie L. Sulcen

19a. Informant's Name/Relationship (Type, Print)

Dianne R. Bowers, Daughter 3246 Jefferson Pike, Jefferson MD 21755

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark's Cemetery 4/26

Date

20c. Location - City or Town, State

Petersville, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home  
100 Petersville Rd Brunswick MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHF

Due to (or as a consequence of):

Years

c. COPD

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew Zarick, Jr.

29c. License number

D3514

29d. Date signed (Month, Day, Year)

4/24/93

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarick, Jr., M.D. FAA.F.P. 130 Thomas Johnson Drive Frederick MD 21702

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

John A. Anderson

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14709

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessie L. K. Keepers				2. Date of Death Month: April Day: 22 Year: 1996		3. Time of Death 1:03 AM	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 216-07-2085		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 8, 1918	
	9. Birthplace (State or Foreign Country) BALTIMORE, CITY		10a. State MD		10b. County FREDERICK		10c. City, Town or Location THURMONT,	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1 SANDY SPRING CT.		10f. Zip Code 21788		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SHOE REPAIR		16b. Kind of Business/Industry SHOE FACTORY			
	17. Father's Name (First, Middle, Last) LEE K. McBEE				18. Mother's Name (First, Middle, Maiden Surname) ELLA B. HERR			
	19a. Informant's Name/Relationship (Type, Print) PAUL A. KEEPERS, HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 SANDY SPRING CT., THURMONT, MD. 21788			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. TABOR		20c. Location - City or Town, State 4/25/96 ROCKY RIDGE, MD.			
	21. Signature of Funeral Service Licensee <i>John M. Skiles</i>				22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <i>Coronary Heart Failure</i> Due to (or as a consequence of): b. <i>Cerebral Small Cell</i> Due to (or as a consequence of): c. <i>CA Lung</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 day 1 mo							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ischemic Sepsis</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 14620		29d. Date signed (Month, Day, Year) APR 23, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORY P. RAUSCH, 501 W. 7TH ST. FREDERICK, MD 21701							
State Registrar	31. Date filed (Month, Day, Year) APR 24 1996		32. Registrar's Signature <i>John A. Rausch</i>					

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020


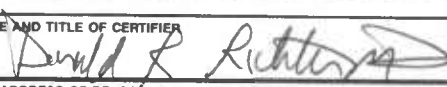

3



96 14710

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANKLIN HUNTER KARN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>5</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>9:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-48-4928</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) <b>MAY 3, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>DENNETT ROAD MANOR NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>		9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>		10c. CITY, TOWN OR LOCATION <b>OAKLAND</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12TH STREET &amp; MARY DRIVE</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NEVER WORKED (invalid)</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>RUSSELL DUDROW KARN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HAZEL OPHELIA MARLOWE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAURA PULLEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24301 KAKAE DR. DAMASCUS, MD 20872</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OMEGA CREMATORY</b>		DATE <b>5/6</b>		20c. LOCATION — City or Town, State <b>MORGANTOWN, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MOO167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>POSSIBLE PNEUMONIA</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>1 1/2 WEEKS</b>  <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HISTORY OF MENTAL RETARDATION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30035</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/6/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD R. RICHTER, M.D. OAKLAND, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

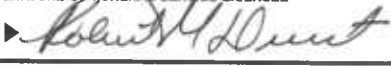

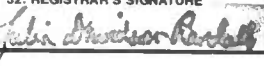
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14711

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES PAUL KEMPFER, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 6, 1996</b>		3. TIME OF DEATH <b>8:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-7495</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 24, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>		9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>		10c. CITY, TOWN OR LOCATION <b>OAKLAND</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>985 E. HIGH STREET</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOCK WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TRUCKING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES PAUL KEMPFER, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CHARLOTTE HOGUE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLAUDINE KEMPFER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>985 E. HIGH ST. OAKLAND, MD 21550</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. PAUL'S CEMETERY</b>		20c. DATE <b>5/8</b>		20d. LOCATION — City or Town, State <b>ACCIDENT, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME -- OAKLAND, MD 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  Due to (or as a consequence of):  <b>DIABETES MELLITUS</b>							Approximate Interval Between Onset and Death <b>2 WEEKS</b>  <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>THOMAS G. JOHNSON, M.D.</b>				29c. LICENSE NUMBER <b>D15333</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/7/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS G. JOHNSON, M.D. 311 N 4TH ST. OAKLAND, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14712

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine C. Leffert</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>30</i> YEAR <i>96</i>		3. TIME OF DEATH <i>12:30 PM</i>	
4. SOCIAL SECURITY NUMBER <i>219-01-5715</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/26/1918</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Carroll Lutheran Village</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i>		10. COUNTY OF DEATH <i>Carroll</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Westminster</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>200 St. Luke Circle</i>				10f. ZIP CODE <i>21158</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Frank Crouse</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bessie Bowers</i>			
19a. INFORMANT'S NAME (Type/Print) <i>S. Doug Leffert, son</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>300 Avalon Lane, Westminster, MD 21158</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Krider's Church Cemetery</i>		20c. LOCATION — City or Town, State <i>Westminster, MD</i>		20d. DATE <i>5/8/96</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Katherine Lutz-Switzer</i>				22. NAME AND ADDRESS OF FACILITY <i>Pritts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Coronary vascular accident</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval between Onset and Death <i>2 days</i>	
		b. <i>Coronary vascular insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>2 years</i>	
		c. <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>15 years</i>	
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i> <i>Hypertension</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel J. Welliver MD</i>				29c. LICENSE NUMBER <i>D11496</i>		29d. DATE SIGNED (Month, Day, Year) <i>5-1-96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DANIEL J. WELLYER MD</i> <i>9120 WASHINGTON ROAD WESTMINSTER MD 21157</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 03 1996</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14713

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Eloise Leister</b>				2. Date of Death Month <b>4</b> Day <b>28</b> Year <b>96</b>		3. Time of Death <b>5:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>433 Silver Run Valley Road</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>212-01-8637</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 7, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>433 Silver Run Valley Rd.</b>		10f. Zip Code <b>21157</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>				16b. Kind of Business/Industry <b>Sewing Factory</b>		17. Father's Name (First, Middle, Last) <b>Charles Brown</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie Graft</b>				19a. Informant's Name/Relationship (Type, Print) <b>Walter Leister, Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>433 Silver Run Valley Rd. Westminster, MD 21157</b>	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Aloysius Cemetery</b>		20c. Location - City or Town, State <b>Littlestown, PA</b>		20d. Date <b>5/1/96</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Richard Little</b>				22. Name and Address of Facility <b>Littles' F.H. 34 Maple Ave. Littlestown, PA 17340</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Ischemic heart disease</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>15 yrs</b> <b>15 yrs</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Robert Fawcett MD</b>				29c. License number <b>MD022143 E</b>		29d. Date signed (Month, Day, Year) <b>4/29/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Fawcett, 111 Penn St, Hanover, PA 17331</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>John Andrew Randall</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14714

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RENA LANE</b>				2. Date of Death Month Day Year <b>APRIL 25, 1996</b>		3. Time of Death <b>2:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MANOR CARE - BETHESDA</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577-7-5698</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>100</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 17 1896</b>	
	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		10a. State <b>WASHINGTON D.C.</b>		10b. County		10c. City, Town or Location <b>WASHINGTON D.C.</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>4201 CATHEDRAL AVENUE N.W. # 1120 E</b>				10f. Zip Code <b>20016</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>UNKNOWN</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
	17. Father's Name (First, Middle, Last) <b>MAYER LEIB SAOUTCHIL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HANNAH " UNKNOWN "</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ADELINE JOJSON ( DAUGHTER )</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5139 NEBRASKA AVENUE NW WASHINGTON DC 20008</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GARDEN</b>		20c. Location - City or Town, State <b>4/28/96 FALLS CHURCH VIRGINIA</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Pneumonia</i></b> Due to (or as a consequence of):  <b>b. <i></i></b> Due to (or as a consequence of):  <b>c. <i></i></b> Due to (or as a consequence of):  <b>d. <i></i></b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 wk</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>			
	29c. License number <b>004179</b>				29d. Date signed (Month, Day, Year) <b>APRIL 26, 1996</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James J. Foster MD. 5530 Wood Chevy Chase Md 20815</b>							
	31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(E)

96 14715

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thomas G. Lantzas</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 26 1996</i>		3. TIME OF DEATH <i>555 PM</i>	
4. SOCIAL SECURITY NUMBER <i>002-16-7426</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>72</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 10, 1923</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Brooke Grove Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Olney</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Rockville</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4501 Bel Pre Road</i>				10f. ZIP CODE <i>20853</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Marketing Manager</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Electric/Appliance Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>George Lantzas</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Tasia Katsouperis</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Tom Lantzas / Son</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4309 Skymist Terrace, Olney, Maryland 20832</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 4/30</i>		20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alan J. Donnell</i>				22. NAME AND ADDRESS OF FACILITY <i>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pulmonary edema</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Severe dilated cardiomyopathy</i> <i>coronary artery disease</i>							Approximate interval between Onset and Death <i>hours</i> <i>years</i> <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic renal insufficiency, ureteral cancer</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Staff Physician</i>				29c. LICENSE NUMBER <i>D42046</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 27, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>G. BROOKE HUFFMAN, MD 1800 Slade School Rd Sandy Spring Maryland 20860</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 01 1996</i>				32. REGISTRAR'S SIGNATURE <i>John A. Hester</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14716

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SIMON LAUPHEIMER</b>				2. Date of Death Month <b>APRIL</b> Day <b>18</b> Year <b>96</b>		3. Time of Death <b>23:05 PM</b>			
	4e. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>578-16-0240</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 22, 1909</b>		9. Birthplace (State or Foreign Country) <b>GERMANY</b>	
	Usual Residence of Decedent									
10e. State		10b. County		10c. City, Town or Location <b>WASHINGTON-DC</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5021 34TH STREET NW</b>				10f. Zip Code <b>20008</b>		10g. Citizen of What Country? <b>UNITED STATES</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>			16b. Kind of Business/Industry <b>RESTAURANT</b>			
17. Father's Name (First, Middle, Last) <b>SAMUEL LAUPHEIMER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HERMINE (UNAVAILABLE)</b>						
19e. Informant's Name/Relationship (Type, Print) <b>MARIANA GRIFF</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5324 WAKEFIELD ROAD-BETHESDA, MD 20816</b>						
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. LEBANON</b>		Date <b>4-21-96</b>		20c. Location - City or Town, State <b>ADELPHI, MARYLAND</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>SUBDURAL HEMATOMA</b> Due to (or as a consequence of): b. <b>DEMENTIA</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONIA</b>										Approximate Interval Between Onset and Death <b>16 DAYS</b> <b>INDEF</b>
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year) <b>APRIL 2 96</b>		28b. Time of Injury <b>18 30P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>FELL</b>		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NURSING HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>#10</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>DOT099</b>		29d. Date signed (Month, Day, Year) <b>APRIL 19 96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FRANK C MAYHE 10215 FERNWOOD RD BETHESDA MD 20817</b>										
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



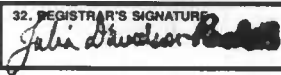
State  
Registrar

3

96 14717

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GENEVIEVE BERNICE LE MARBE				2. DATE OF DEATH MONTH DAY YEAR MAY 1 1996		3. TIME OF DEATH 12:08 A M	
4. SOCIAL SECURITY NUMBER 308-07-4283		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 11, 1917	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11700 Mentone Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Carl F. Zech				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Bernice Stringham			
19a. INFORMANT'S NAME (Type/Print) Edward Le Marbe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11700 Mentone Road, Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 20901 500 University Blvd. W. Silver Spring, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Posterior Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 Days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER X 05568		29d. DATE SIGNED (Month, Day, Year) May 2, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samuel B. Itscoitz 10313 Georgia Avenue #307, Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) MAY 03 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1111. 02



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Beauchamp Lodder

2. Date of Death

May 1, 1996

3. Time of Death

12:13am

4e. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

074-09-3704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 12, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

234 Great Falls Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Commercial Artist

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

James Street Lodder

18. Mother's Name (First, Middle, Maiden Surname)

Grace Beauchamp

19a. Informant's Name/Relationship (Type, Print)

Adrienne G. Lodder

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

234 Great Falls Road, Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lake View Cemetery

Date

5/4/96

20c. Location - City or Town, State

Skaneateles, NY

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Weeks

b. Pneumonia

Due to (or as a consequence of):

Weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28b. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel R. Schulman

140

29c. License number

D 20516

29d. Date signed (Month, Day, Year)

May 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel R. Schulman, MD 9410 Old Georgetown Road, Bethesda, MD 20814-1700

31. Date filed (Month, Day, Year)

MAY 02 1996

32. Registrar's Signature

John Davidson-Rose

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death in the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14719

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah J. Lord				2. Date of Death Month Day Year May 1, 1996		3. Time of Death 2:45 PM				
	4a. Facility Name (If not institution, give street and number) 20720 Bountyfield Place				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 101-28-9859		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 26, 1934		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 20720 Bountyfield Place				10f. Zip Code 20879		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business/Industry Nursing Home				
17. Father's Name (First, Middle, Last) Floyd Masland				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Ruff							
19a. Informant's Name/Relationship (Type, Print) Alan W. Lord / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20720 Bountyfield Place, Gaithersburg, MD 20879							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date 5-10-96		20c. Location - City or Town, State Rockville, Maryland					
21. Signature of Funeral Service Licensee Ellen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 years										Approximate Interval Between Onset and Death 4 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29f. Signature and title of certifier Joseph M. Haggerty				29c. License number D 3 2407		29d. Date signed (Month, Day, Year) May 2, 1996					
30. Name and address of person who completed cause of death (Part 23a) (Type, Print) Joseph M. Haggerty, M.D., 10605 Concord St., #300, Kensington, MD 20895											
31. Date filed (Month, Day, Year) MAY 02 1996				32. Registrar's Signature John Davidson-Harris							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14720

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Smith Luhn				2. Date of Death Month Day Year April 29 1996		3. Time of Death 7:13 AM	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-44-7046		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 17, 1923	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Brookeville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19121 Alpenglow Lane		10f. Zip Code 20833		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inventory Liason		16b. Kind of Business/Industry National Institute of Health			
	17. Father's Name (First, Middle, Last) Leslie Luhn				18. Mother's Name (First, Middle, Maiden Surname) Annie Leather			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ruth E. Luhn				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19121 Alpenglow Lane, Brookeville, MD 20833			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		Date 5/2/96		20c. Location - City or Town, State Rockville, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>James S. Dooley</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. myocardial infarction Due to (or as a consequence of): b. metastatic carcinoma - unknown primary Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death One Day Six months
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D33888		29d. Date signed (Month, Day, Year) April 29, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurtin M. Luhn 18111 Pine Philip Dr. Olney, MD 20833							
State Registrar	31. Date filed (Month, Day, Year) MAY 02 1996		32. Registrar's Signature <i>[Signature]</i>					

3

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State of Maryland / Department of Health and Mental Hygiene

96 14721

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ILYA LURYE				2. Date of Death Month Day Year APRIL 30, 1996				3. Time of Death 1315 PM					
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 218-37-0105		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 3/11/1932		9. Birthplace (State or Foreign Country) RUSSIA					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 321 N. VAN BUREN STREET				10f. Zip Code 20850				10g. Citizen of What Country? RUSSIA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRONIC TECHNICIAN				16b. Kind of Business/Industry ELECTRONICS					
	17. Father's Name (First, Middle, Last) BORIS LURYE				18. Mother's Name (First, Middle, Maiden Surname) ZINA ADLIM									
	19a. Informant's Name/Relationship (Type, Print) ANETA LURYE, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 N. VAN BUREN STREET, ROCKVILLE, MD 20850									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS		Date 5/2/96		20c. Location - City or Town, State OLNEY, MARYLAND					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852									
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				a. GRAM NEGATIVE SEPTICEMIA Due to (or as a consequence of):				4 DAYS				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				b. LEUKOPENIA Due to (or as a consequence of):				5 DAYS						
				c. LUNG CANCER Due to (or as a consequence of):				18 MONTHS						
				d.										
				Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D 26540		29d. Date signed (Month, Day, Year) APRIL 30, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. SCHOENBERGER, M.D., 16220 FREDERICK ROAD, GAITHERSBURG, MD 20877														
State Registrar	31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 14722

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Verna D. Lussier</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>9:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Hyatt Classic Residence</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>161-50-9110</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 4, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Birmingham, AL</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>	
To Be Completed by Funeral Director	10a. Street and Number <b>8100 Connecticut Avenue</b>		10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Proprietor</b>		16b. Kind of Business/Industry <b>Clothing Store</b>			
	17. Father's Name (First, Middle, Last) <b>John Durfield</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Verna Deacy</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Joyce Ann Lussier</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1612-A Blemont Street, N.W., Washington, D.C. 20009</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>		Date <b>5/1/96</b>		20c. Location - City or Town, State <b>West Conshohocken, PA 19428</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D36797</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan R. Sheff M.D. 10215 Fernwood Road #100, Bethesda, Maryland 20817</b>							
31. Date filed (Month, Day, Year) <b>MAY 02 1996</b>				32. Registrar's Signature 				

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

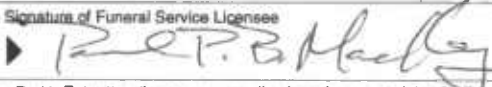

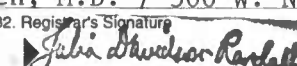
Certificate of Death

Reg. No.

96 14723

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>HERMAN THOMAS LEWIS</b>				2. Date of Death Month Day Year <b>April 29, 1996</b>		3. Time of Death <b>11:30 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Northampton Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>218-24-7650</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 28, 1931</b>	
9. Birthplace (State or Foreign Country) <b>W. Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>517 S. Market St.</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collage (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>		16b. Kind of Business/Industry <b>U.S. Government</b>			
17. Father's Name (First, Middle, Last) <b>Earnest Davis Lewis</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Maryanna Russ</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Florence Stone Lewis / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>517 S. Market St. / Frederick, Maryland 21701</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Memorial</b>		20c. Location - City or Town, State <b>5-3-96 Frederick, Maryland</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>1621 Opossumtown Pike, Frederick, Md. 21702</b>		23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. <b>Sub-acute renal failure</b> Due to (or as a consequence of): <b>Arteriosclerotic cardiovascular disease 30 years</b> Due to (or as a consequence of): <b>Severe hypertension, multiple strokes, severe osteoarthritis of left knee - recent knee replacement</b> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		25. Signature and Title of certifier 		26. License number <b>D 35183</b>	
27. Date signed (Month, Day, Year) <b>4/30/96</b>		28. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali James Aftookteh, M.D. / 300 W. Ninth St. / Frederick, Maryland</b>		29. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		30. Registrar's Signature 	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(E)

96 14724

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Harry Grafton Lowman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1996</b>		3. TIME OF DEATH <b>12:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-34-6450</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 19, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Health Care Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Mt. Airy</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13046 Penn Shop Rd.</b>		10f. ZIP CODE <b>21771</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dairy Farming</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Grafton Lowman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nettie Roberts Lowman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ada Mae Lowman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13046 Penn Shop Rd., Mt. Airy, MD 21771</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Pine Grove Cemetery</b>		20c. LOCATION — City or Town, State <b>1996 Mt. Airy, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kyran M. Berger</i>				22. NAME AND ADDRESS OF FACILITY <b>Stauffer Funeral Home</b> <b>8 E. Ridgeville Blvd., Mt. Airy, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Coronary Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> d. <b>COPD</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald E. Miller</i>				29c. LICENSE NUMBER <b>D26499</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-24-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ronald E. Miller, MD, 4, Culwell Dr., Mt. Airy, MD 21771</b>							
31. DATE FILED (Month, Day, Year) <b>APR 29 1996</b>		32. REGISTRAR'S SIGNATURE <i>David R. Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ASTM 1.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14725

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY MARGARET LONGRIDGE</b>				2. Date of Death Month Day Year <b>MAY 6 1996</b>		3. Time of Death <b>10:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>212-38-5690</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 4 1898</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Barton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Box 161 Bartlett St.</b>		10f. Zip Code <b>21521</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Education</b>				
17. Father's Name (First, Middle, Last) <b>Robert T. Longridge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Finch</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Elaine Fisher</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>517 Hayes Ave. Morgantown, WV 26505</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Laurel Hill Cemetery 5-8-96</b>		20c. Location - City or Town, State <b>Barton, Md.</b>				
21. Signature of Funeral Service Licensee <i>Wayne Boal</i>				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St. Westernport, Md. 21562</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Arteric Stenosis, atrial fibrillation</b> <b>hypothyroidism</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Cheryl Berlin MD</i>				29c. License number <b>D21408</b>		29d. Date signed (Month, Day, Year) <b>MAY 6 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas J. Berlin MD, 20 Douglas Ave Lomax, Md 21539</b>								
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature <i>John Anderson</i>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

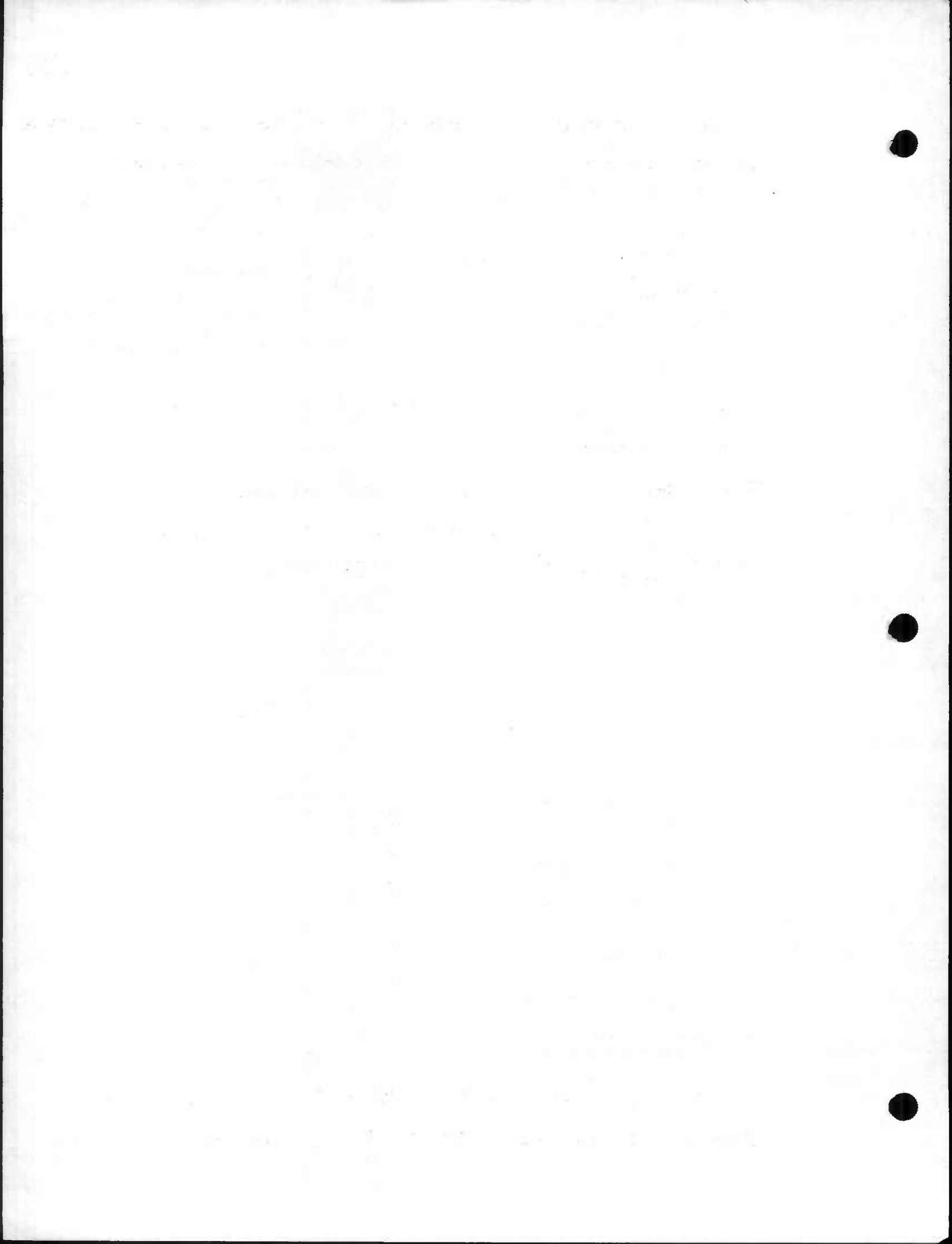
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

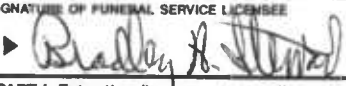





96 14726

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Cecil Paul LAYTON				2. DATE OF DEATH MONTH DAY YEAR April 29, 1996				3. TIME OF DEATH 9:00 PM M					
4. SOCIAL SECURITY NUMBER 236-20-9776		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1911		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Oakland				9c. COUNTY OF DEATH Garrett			
10a. STATE WV				10b. COUNTY Grant				10c. CITY, TOWN OR LOCATION Bayard				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 127						10f. ZIP CODE 26707				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lumberman				15b. KIND OF BUSINESS/INDUSTRY Sawmill & Logging					
17. FATHER'S NAME (First, Middle, Last) Olen ----- Layton						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada C. Nordeck							
19a. INFORMANT'S NAME (Type/Print) Gerladine K. Layton						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 127, Bayard, WV 26707							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bayard Cemetery				20c. DATE 5/2		20d. LOCATION — City or Town, State Bayard, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory failure due to COPD (chronic obstructive pulmonary disease)</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death years													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>gastrointestinal bleeding</u>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Patricia R. Gotsch				29c. LICENSE NUMBER D45071		29d. DATE SIGNED (Month, Day, Year) 5/1/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Patricia Gotsch, MD 311 N. Fourth St., Oakland, MD 21550													
31. DATE FILED (Month, Day, Year) MAY 02 1996				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14727

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Larry Eugene Myers</b>				2. Date of Death Month Day Year <b>Apr 27, 1996</b>		3. Time of Death <b>0910 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>3050 South Main Street</b>				4b. City, Town, or Location of Death <b>Manchester</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>218-46-3893</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 13, 1947</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedant							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Manchester</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3050 South Main Street</b>			10f. Zip Code <b>21102</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>Jack H. Kidd Assoc</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas Byerly Myers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Erma R. Therit</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Victoria Lee Myers</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4205 Hanover Pike, Manchester, MD 21102</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Veterans Cem</b>		20c. Location - City or Town, State <b>5/1 Owings Mills, MD</b>			
	21. Signature of Funeral Service Licensee <b>Steve W. Eline</b>			22. Name and Address of Facility <b>Eline Funeral Home 934 S Main St, Hampstead, MD 21074</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>ARRHYTHMIA</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>MINS.</b>  <b>YRS.</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Therese Neil Phelps M.D. DEPUTY MED EXAMINER</b>			29c. License number <b>D36908</b>		29d. Date signed (Month, Day, Year) <b>29/APR/96</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11722 REISTERSTOWN RD. REISTERSTOWN MD 21136</b>							
	31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature <b>John H. ...</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14728

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>PATRICK B Mahoney</b>				2. Date of Death Month Day Year <b>April 27, 1996</b>		3. Time of Death <b>9:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>119-24-6742</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 12, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3814 Bel Pre Road Apt.#3</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>Union Labor Life Ins.</b>			
	17. Father's Name (First, Middle, Last) <b>Patrick Mahoney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Dee</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Beatrice A. Mahoney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3814 Bel Pre Road, Apt.#3 Silver Spring, Maryland 20906</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Date <b>4/30/96</b>		20d. Location - City or Town, State <b>Silver Spring, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>Chronic Liver Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>1 year</p> <p>3 years</p> </div> </div>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D 21340</b>		29d. Date signed (Month, Day, Year) <b>APRIL 27, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAYMOND BASS 3941 Ferrara Dr Wheaton, Md 20906</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14729

Amended #8, 4/29/96, MRT, Montg. Cty. *Certificate of Death*

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Stewart Martin</b>				2. Date of Death Month <b>4</b> Day <b>20</b> Year <b>96</b>		3. Time of Death <b>11:00 p.m.</b>		
	4e. Facility Name (If not institution, give street and number) <b>5837 Marbury Road</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>578-01-0950</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6/20/96</b>		
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5837 Marbury Road</b>		10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Reproduction Equipment</b>					
17. Father's Name (First, Middle, Last) <b>John Solomon Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mae Pearl Clifton</b>					
19a. Informant's Name/Relationship (Type, Print) <b>James C. Martin - Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5837 Marbury Road, Bethesda, MD 20817</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Faison Cemetery</b>		20c. Date <b>4/27/96</b>		20d. Location - City or Town, State <b>Faison, N.C.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph Gawler's Sons</b> <b>5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Prostate Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>8 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)							
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>033293</b>		29d. Date signed (Month, Day, Year) <b>4-22-96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick Smith, M.D., 5401 Western Avenue, N.W., Washington, D.C. 20015</b>									
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar





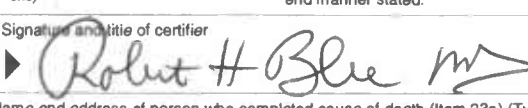
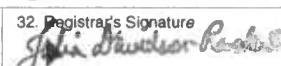
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14730

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Photios Adam Mavridis				2. Date of Death Month Day Year April 26, 1996				3. Time of Death 8:50 AM												
	4a. Facility Name (If not institution, give street and number) 7309 River Falls Drive				4b. City, Town, or Location of Death Potomac				4c. County of Death Montgomery												
Funeral Director	5. Social Security Number 578-40-5084		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) July 27, 1927		9. Birthplace (State or Foreign Country) Greece												
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
	10e. Street and Number 7309 River Falls Drive				10f. Zip Code 20854		10g. Citizen of What Country? USA														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Care Specialist				16b. Kind of Business/Industry Veteran's Admin.														
	17. Father's Name (First, Middle, Last) Adam Mavridis				18. Mother's Name (First, Middle, Maiden Surname) Zoe Banios																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lydia Mavridis / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7309 River Falls Drive, Potomac, Maryland 20854																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 4/29/96		20c. Location - City or Town, State Silver Spring, Maryland														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Squamous Cell Carcinoma of Head and Neck-Metastatic</td> <td>1.5 years</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Squamous Cell Carcinoma of Head and Neck-Metastatic	1.5 years	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death)	a. Squamous Cell Carcinoma of Head and Neck-Metastatic	1.5 years																			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																				
	c. Due to (or as a consequence of):																				
	d. Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred													
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier 				29c. License number D-23556		29d. Date signed (Month, Day, Year) April 26, 1996															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert H. Blee, M.D. 5530 Wisconsin Avenue, #1400, Chevy Chase, Maryland 20815																					
31. Date filed (Month, Day, Year) APR 29 1996				32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 14731

Amended #18, 5/3/96, MRT, Montgomery County

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM METSCHER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26 1996</b>		3. TIME OF DEATH <b>5:27 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>071-24-8378</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 4, 1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Derwood</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>	
10e. STREET AND NUMBER <b>16805 Baederwood Lane</b>				10f. ZIP CODE <b>20855</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>1950-1974</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b> <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice Commander</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Research and Development</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Metscher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Meta Schweter Schlueter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene W. Metscher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16805 Baederwood Lane, Derwood, Maryland 20855</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>May 2, 1996</b> <b>Arlington National Cemetery</b>		20c. LOCATION — City or Town, State <b>Arlington, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Barbara J. McMullen Lawrence</b> M00831				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>OVERWHELMING PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John H. Kellogg MD</b>				29c. LICENSE NUMBER <b>MD-047454-L (PA)</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J.H. KELLOGG, LCDR, MC, USN</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 01 1996</b>				32. REGISTRAR'S SIGNATURE <b>John H. Kellogg</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

16507 1-1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

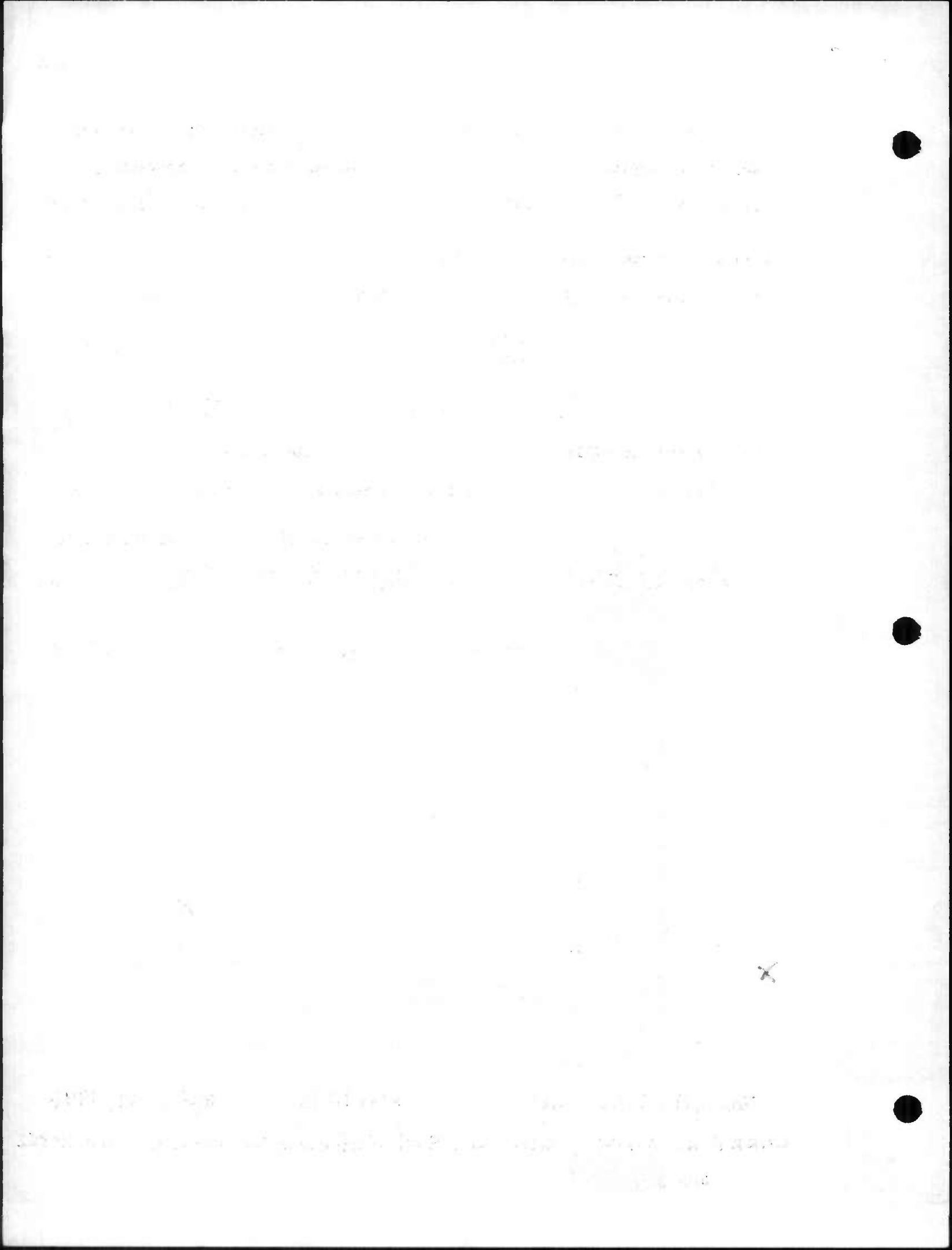
State of Maryland / Department of Health and Mental Hygiene

96 14732

Amended #7, 4/30/96, MRT, Montg. Cty. **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Dabney Miller</b>				2. Date of Death Month Day Year <b>April 26 1996</b>		3. Time of Death <b>10:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-32-5592</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 6, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Laurel</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>13625 Avebury Drive #12</b>				10f. Zip Code <b>20708</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1948-</b> If Yes, Give Year or Dates: <b>1990</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Communications</b>		16b. Kind of Business/Industry <b>Bell Atlantic Telephone Company</b>			
	17. Father's Name (First, Middle, Last) <b>William Braxton Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Lenor</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dana B. Miller</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21255 Corral Hollow Road, Tracy, California 95376</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Data <b>5/1/96</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
	21. Signature of Funeral Service Director <i>Steven D. Grindel</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>metastatic lung cancer</i></b> Due to (or as a consequence of):  <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Larry A. Oates MD</b>				29c. License number <b>341926</b>		29d. Date signed (Month, Day, Year) <b>April 27, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LARRY A. OATES M.D. 2101 East Jefferson St. Rockville Md 20852</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>				32. Registrar's Signature <i>John Davidson</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14733

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE M. MOHR				2. Date of Death Month Day Year April 29, 1996				3. Time of Death 3:25 P.M.							
	4a. Facility Name (If not institution, give street and number) Hillhaven Nursing Home				4b. City, Town, or Location of Death Adelphi				4c. County of Death Prince George's							
Funeral Director	5. Social Security Number 335-22-1537		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 101 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 5, 1894		9. Birthplace (State or Foreign Country) Illinois							
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 2320 Parallel Lane				10f. Zip Code 20904		10g. Citizen of What Country? USA									
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education									
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Alpheas Milleson				18. Mother's Name (First, Middle, Maiden Surname) Perlina Ott											
	19a. Informant's Name/Relationship (Type, Print) Roberta Belsley / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Parallel Lane, Silver Spring, Maryland 20904											
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkview Cemetery		Date 5/2/96		20c. Location - City or Town, State Peoria, Illinois									
	21. Signature of Funeral Service Licensee Alan J. Donnell		22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904													
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Pneumonia Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 MONTH							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Andrew Kunokat		29c. License number 036716		29d. Date signed (Month, Day, Year) 4/30/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW KUNOKAT, 8317 CHERRY LANE, LAUREL, MD 20707															
State Registrar	31. Date filed (Month, Day, Year) MAY 01 1996				32. Registrar's Signature John Anderson-Rand											

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96 14734

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>George H. Meyers</u>				2. DATE OF DEATH MONTH <u>04</u> DAY <u>29</u> YEAR <u>96</u>		3. TIME OF DEATH <u>10:30</u> M	
4. SOCIAL SECURITY NUMBER <u>213-03-6759</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>93</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 23, 1902</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Calvert Manor Nursing Home</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Rising Sun</u>		9c. COUNTY OF DEATH <u>Cecil</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>aberddeen</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>166 Mt. Royal Avenue</u>				10f. ZIP CODE <u>21001</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>3</u> College (1-4 or 5+) <u>0</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Welder</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Bethlehem Steel</u>			
17. FATHER'S NAME (First, Middle, Last) <u>George H. Meyers</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rose Ella Redmond</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Paul L. Grant</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>166 Mt. Royal Ave., Aberdeen, Maryland 21001</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Poplar United Methodist Cem</u>		OATE <u>5/2</u>		20c. LOCATION — City or Town, State <u>Sparks, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Mary R. DiGiovanni</u>				22. NAME AND ADDRESS OF FACILITY <u>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CHF</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>CAD - EOPD</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dudley R. Pullen MD</u>				29c. LICENSE NUMBER <u>D09482</u>		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <u>MAY 1 - 1996</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14735

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONARD Medders</b>				2. Date of Death Month Day Year <b>May 1 1996</b>		3. Time of Death <b>1253P</b>		
	4e. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Harford</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>515-18-1583</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 28, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>Wisconsin</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>890 Avon Drive</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self employed</b>		16b. Kind of Business/Industry <b>General Contractor</b>		17. Father's Name (First, Middle, Last) <b>Leroy Medders</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Maxon</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Patience Lynn Raab</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>890 Avon Drive, Aberdeen, Maryland 21001</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Silverbrook Cemetery</b>		20c. Location - City or Town, State <b>5/6/96 Elsmere, Delaware</b>	
21. Signature of Funeral Service Licensee <b>Mary R. DiMiovanni</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Congestive heart Failure Exacerbation</b> Due to (or as a consequence of): b. <b>Coronary Artery Disease</b> Due to (or as a consequence of): c. <b>S/P Coronary Artery Bypass Grafting</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>Days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MIRZA A. BAIG</b>		29c. License number <b>DC 3115</b>		29d. Date signed (Month, Day, Year) <b>5-2-96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		31. Date filed (Month, Day, Year) <b>MAY 6 - 1996</b>		32. Registrar's Signature <b>Davidson-Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14736

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE ROSIE MANDLEY</b>				2. Date of Death Month <b>MAY</b> 5, 1996 Day Year		3. Time of Death <b>2:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1855 BARTLETT STREET</b>				4b. City, Town, or Location of Death <b>MECHANICSVILLE</b>		4c. County of Death <b>ST. MARY'S</b>	
Funeral Director	5. Social Security Number <b>213-38-0585</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 11, 1943</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>ST. MARY'S</b>		10c. City, Town or Location <b>MECHANICSVILLE</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1855 BARTLETT STREET</b>				10f. Zip Code <b>20659</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>		16b. Kind of Business/Industry <b>STATE OF MARYLAND MOTOR VEHICLE ADM.</b>		
17. Father's Name (First, Middle, Last) <b>ALBERT T. WEEKS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SUSIE B. RILEY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>PAMELA C. KING - DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1855 BARTLETT ST., MECHANICSVILLE, MD. 20659</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDENS</b>		20c. Location - City or Town, State <b>MAY 8, 1996 WALDORF, MD.</b>		
21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN M00053</b>				22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CANCER OF LUNG</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 yrs.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Heather M. Noon</b>		29c. License number <b>D 28352</b>		29d. Date signed (Month, Day, Year) <b>MAY 6, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KRISHAN MATHUR, M.D., 3800 OLD WASHINGTON RD., #102, WALDORF, MARYLAND 20602-3208</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

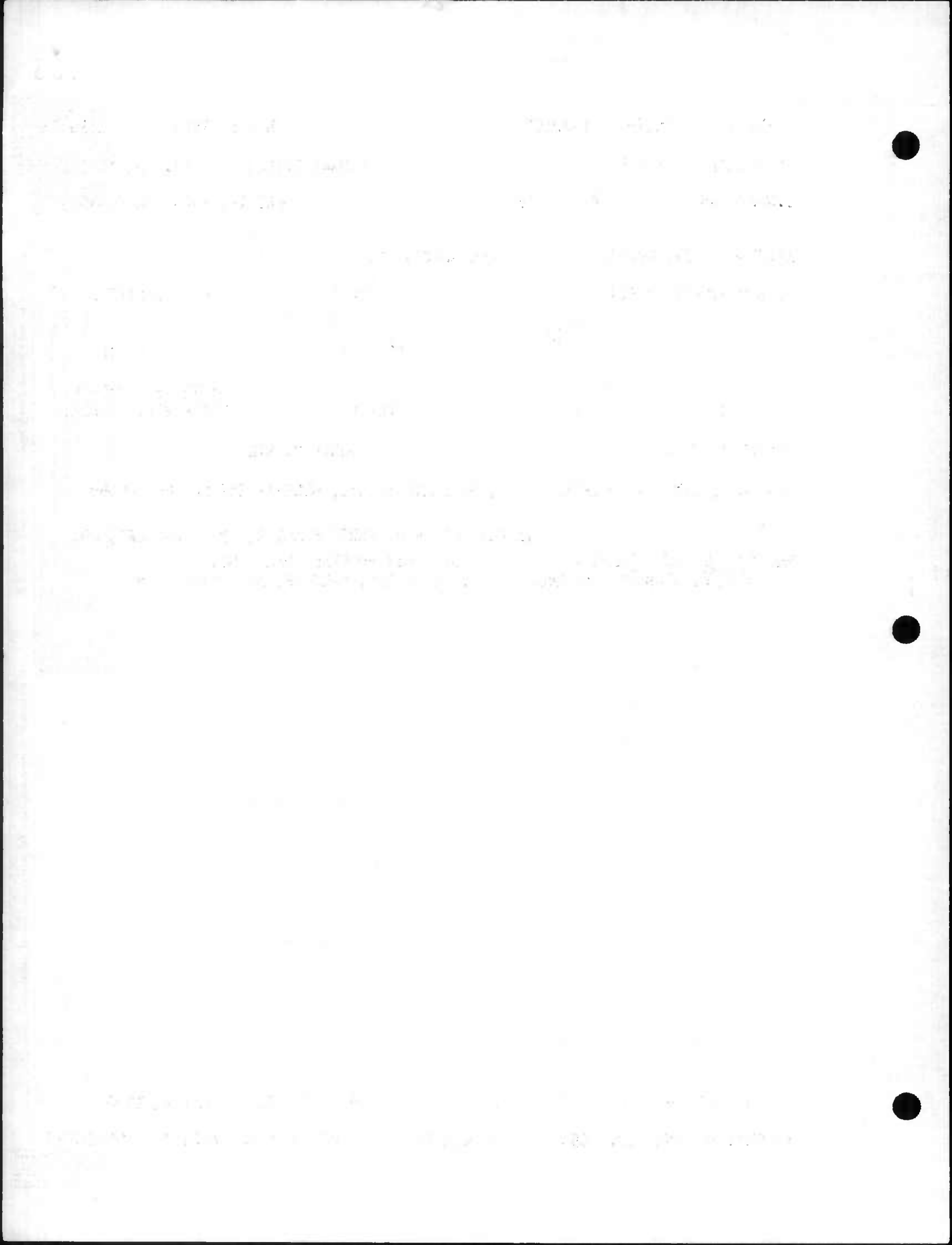
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



96 14737

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Daisy Moore</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4 26 1996</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>214-20-1566</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-29-1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Elkton, Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>555 Booth Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Elkton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>555 Booth Street</b>				10f. ZIP CODE <b>21921</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Housewife</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Arthur G. Gibbs</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Francis Scott</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sandy Matthews</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 Milestone Rd. Elkton, Maryland 21921</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Delaware Veterans Mem. Cemetery</b>		20c. LOCATION — City or Town, State <b>Bear, Delaware</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles D. Congo</i>				22. NAME AND ADDRESS OF FACILITY <b>Congo Funeral Home P.O. Box 2593 Wilm., De</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ARTERIOSCLEROTIC CORONARY VASCULAR DIS.</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>HYPERTENSIVE SEC. ARTERIOSCLEROSIS</b>							Approximate Interval Between Onset and Death <b>3 wks.</b> <b>3 wks.</b> <b>3 wks.</b> <b>3 wks.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. ...</i>				29c. LICENSE NUMBER <b>D07463</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Rolando Najera 118 North St, Elkton MD 21921</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1996</b>		32. REGISTRAR'S SIGNATURE <i>John H. ...</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14738

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Ann Messick</b>				2. Date of Death Month <b>April</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>0433</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>223-30-1924</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 24, 1928</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>	
Usual Residence of Decedent		10e. Street and Number <b>27 Leedom Road</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Hospital</b>				
17. Father's Name (First, Middle, Last) <b>Harry C. Blakemore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary A. Gray</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Brenda S. Cartwright</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Colonial Circle - North East, MD 21901</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodbine Cemetery</b>		20c. Location - City or Town, State <b>Harrisonburg, VA</b>		20d. Date <b>5-2 1996</b>		
21. Signature of Funeral Service Licensee <b>Doreen S. Hicks</b>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Massive myocardial infarction</b> Due to (or as a consequence of): b. <b>Coronary Artery Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>72 hours</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Previous MI 10 yrs ago.</b> <b>Previous major CVA left hemiplegia 1 1/2 yrs.</b> <b>Fall 5 days before admission - fracture of humerus</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Wallace O'Brien, M.D.</b>				29c. License number <b>D07129</b>		29d. Date signed (Month, Day, Year) <b>29 Apr 96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WALLACE O'BRIEN, M.D. Cecilton, md 21913</b>								
31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>				32. Registrar's Signature <b>Julia [Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ADA S. MAIN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>29</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-40-8153</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 23, 1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Brooke Grove Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Germantown</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>23621 Ridge Road</b>				10f. ZIP CODE <b>20876</b>		10g. CITIZEN OF WHAT COUNTRY? <b>American</b>	
11. MARITAL STATUS <b>3 X Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own home.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ira W. Mullinix</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Iona Williams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dennis W. Main</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Post Office Box 292, Damascus, Maryland 20872</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salem Cemetery 5/2</b>		20c. LOCATION — City or Town, State <b>Germantown, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert L. Williams</b>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death <b>18 Hours</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cachexia</b> <b>Dementia</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>
25. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 X Nursing Home 5 Residence 6 Other (Specify)</b>				27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ted E. Howe, M.D.</b>				29c. LICENSE NUMBER <b>D33700</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 29, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ted E. Howe, M. D. 18100 Slade School Road Sandy Spring, Maryland 20860</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14740

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Ruth Messner						2. Date of Death Month Day Year April 29, 1996		3. Time of Death 12:45 PM		
	4a. Facility Name (If not institution, give street and number) 132 Water Street						4b. City, Town, or Location of Death Thurmont		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 220-18-1210		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 7, 1924		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 132 Water Street				10f. Zip Code 21788		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Clothing Factory				
17. Father's Name (First, Middle, Last) Robert Leroy Miller						18. Mother's Name (First, Middle, Maiden Surname) Hazel Ellen Lewis Miller					
19a. Informant's Name/Relationship (Type, Print) Larry W. Messner, son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D. 14, Box 372 B-1 Dover, Pennsylvania 17315					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		Date 5/1/96		20c. Location - City or Town, State Thurmont, Maryland			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, MD 21788					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Metastatic Adenocarcinoma of Colon Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death Months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-17549		29d. Date signed (Month, Day, Year) 4/30/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William F. Harper, M.D. 100 S. Center Street Thurmont, Maryland 21788											
31. Date filed (Month, Day, Year) MAY 01 1996		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
main problems which  
the government is  
facing at the moment.  
The second part of the  
report deals with the  
social and cultural  
aspects of the country.  
It describes the  
education system and  
the health services.  
The third part of the  
report discusses the  
environmental situation  
and the measures taken  
to protect the environment.  
The fourth part of the  
report deals with the  
foreign relations of the  
country and the role  
of the country in the  
international community.  
The fifth part of the  
report discusses the  
future prospects of the  
country and the  
challenges it faces.

2. The second part of the report  
describes the social and cultural  
aspects of the country.  
It mentions the main  
problems which the  
government is facing  
at the moment.  
The third part of the  
report discusses the  
environmental situation  
and the measures taken  
to protect the environment.  
The fourth part of the  
report deals with the  
foreign relations of the  
country and the role  
of the country in the  
international community.  
The fifth part of the  
report discusses the  
future prospects of the  
country and the  
challenges it faces.

3. The third part of the report  
describes the environmental  
situation and the  
measures taken to  
protect the environment.  
It mentions the main  
problems which the  
government is facing  
at the moment.  
The fourth part of the  
report deals with the  
foreign relations of the  
country and the role  
of the country in the  
international community.  
The fifth part of the  
report discusses the  
future prospects of the  
country and the  
challenges it faces.

4. The fourth part of the report  
deals with the foreign  
relations of the country  
and the role of the  
country in the  
international community.  
It mentions the main  
problems which the  
government is facing  
at the moment.  
The fifth part of the  
report discusses the  
future prospects of the  
country and the  
challenges it faces.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14741

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Luther Franklin MURRAY, JR.				2. Date of Death Month Day Year April 27, 1996				3. Time of Death 4:45 AM																																								
	4a. Facility Name (If not institution, give street and number) 9298 Carlton Circle				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick																																								
Funeral Director	5. Social Security Number 214-10-2015		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth Month Day Year July 10, 1917		9. Birthplace (State or Foreign Country) Maryland																																								
	Usual Residence of Decedent																																																
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																								
	10e. Street and Number 9298 Carlton Circle				10f. Zip Code 21702				10g. Citizen of What Country? U.S.A.																																								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																																								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sports Director				16b. Kind of Business/Industry US Government																																								
	17. Father's Name (First, Middle, Last) Luther Franklin MURRAY, SR.						18. Mother's Name (First, Middle, Maiden Surname) Vera KLINE																																										
	19e. Informant's Name/Relationship (Type, Print) Mrs. Eleanor V. Murray, Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9298 Carlton Circle, Frederick, Maryland 21702																																										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, May 1, 1996				20c. Location - City or Town, State Smithsburg, Maryland																																								
	21. Signature of Funeral Service Licensee Richard E. [Signature] MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701																																												
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Amyloidosis</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death 4 Mos</td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>												Immediate Cause (Final disease or condition resulting in death)	a. Amyloidosis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 Mos	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):																										
Immediate Cause (Final disease or condition resulting in death)	a. Amyloidosis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 Mos																																														
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	c.	Due to (or as a consequence of):																																															
	d.	Due to (or as a consequence of):																																															
<table border="0"> <tr> <td colspan="8">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease Emphysema</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="8"></td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>												Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease Emphysema								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
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<table border="0"> <tr> <td colspan="4">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="4">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="4">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>												25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																									
<table border="0"> <tr> <td colspan="12">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="6">29b. Signature and title of certifier Austin Pearre, Jr.</td> <td colspan="3">29c. License number D 09689</td> <td colspan="3">29d. Date signed (Month, Day, Year) April 29, 1996</td> </tr> </table>												29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												29b. Signature and title of certifier Austin Pearre, Jr.						29c. License number D 09689			29d. Date signed (Month, Day, Year) April 29, 1996																
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29b. Signature and title of certifier Austin Pearre, Jr.						29c. License number D 09689			29d. Date signed (Month, Day, Year) April 29, 1996																																								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. A. Austin Pearre, Jr. MD 300 West Ninth Street, Frederick, Md. 21701																																																	
<table border="0"> <tr> <td colspan="6">31. Date filed (Month, Day, Year) APR 29 1996</td> <td colspan="6">32. Registrar's Signature John Brandon Randall</td> </tr> </table>												31. Date filed (Month, Day, Year) APR 29 1996						32. Registrar's Signature John Brandon Randall																															
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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 14742

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Edward MORGAN</b>						2. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1996</b>		3. TIME OF DEATH M <b>1:00 PM</b>			
4. SOCIAL SECURITY NUMBER <b>218-24-1927</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 1, 1931</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>206 East Seventh Street</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>206 East Seventh Street</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Feb. 1957 to Oct. 1957</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Concrete worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Paving Company</b>							
17. FATHER'S NAME (First, Middle, Last) <b>George E. Morgan</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret A. Newton</b>					
19a. INFORMANT'S NAME (Type/Print) <b>James Edward Wheeldon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 3073, Frederick, Md. 21705</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery April 23, 1996</b>		20c. LOCATION — City or Town, State <b>Frederick, Md. 21701</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. O. Basford</i> 00021				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> e. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): <b>13 Years</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema and chronic bronchitis</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. Kusay Barakat</i>						29c. LICENSE NUMBER <b>D 21648</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 19, 1996</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Kusay Barakat MD 310 West Ninth Street, Frederick, Maryland 21701</b>											
31. DATE FILED (Month, Day, Year) <b>APR 23 1996</b>		32. REGISTRAR'S SIGNATURE <i>Davidson-Barakat</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14743

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL NMI MARRONE			2. Date of Death Month Day Year APRIL 21, 1996		3. Time of Death 10:35 p.m.	
	4e. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-4380		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 14, 1917
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10e. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 110 Frederick Avenue			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contracting Officer		16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) Carmello Marrone			18. Mother's Name (First, Middle, Maiden Surname) Irena Pacino			
	19a. Informant's Name/Relationship (Type, Print) Kathleen T. Marrone, Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Frederick Avenue, Frederick, MD 21701			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, April 23, 1996		20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee Allan H. Ruby M00703			22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CARDIOMYOPATHY Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL INSUFFICIENCY							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier William H. Johnson MD			29c. License number D47556		29d. Date signed (Month, Day, Year) 4/22/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. JOHNSON MD 56 THOMAS JOHNSON DR., FREDERICK, MD 21702							
31. Date filed (Month, Day, Year) APR 23 1996		32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14744

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Pliny William MOYER				2. DATE OF DEATH MONTH DAY YEAR April 28, 1996		3. TIME OF DEATH 3:00 P M	
4. SOCIAL SECURITY NUMBER 216-18-9815		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 11, 1917	
9a. FACILITY NAME (If not institution, give street and number) 524 Bray School Road				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE MD				10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 524 Bray School Road				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 5th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Roller Operator		16b. KIND OF BUSINESS/INDUSTRY Steel Production			
17. FATHER'S NAME (First, Middle, Last) Leonard Christopher Moyer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah ----- Barnett			
19a. INFORMANT'S NAME (Type/Print) Robin Moyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 586 Bray School Road, Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bray Cemetery		DATE 4/30		20c. LOCATION — City or Town, State Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Bradley A. Stewart</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Dementia w/ Alzheimer's DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatic Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Thomas Johnson</i>		29c. LICENSE NUMBER D15333		29d. DATE SIGNED (Month, Day, Year) 4/29/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, MD 21550							
31. DATE FILED (Month, Day, Year) MAY 06 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


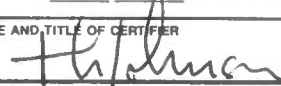



Meyers  
96 14745

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES FREDERICK MEYER</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>30</b> YEAR <b>96</b>		3. TIME OF DEATH <b>0635</b> M					
4. SOCIAL SECURITY NUMBER <b>232-42-4675</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 5, 1927</b>		8. BIRTHPLACE (State or Foreign Country) <b>W. VA.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>			9c. COUNTY OF DEATH <b>GARRETT</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>		10c. CITY, TOWN OR LOCATION <b>OAKLAND</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>639 S. THIRD STREET</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEALER</b>			16b. KIND OF BUSINESS/INDUSTRY <b>AUTOMOBILE</b>					
17. FATHER'S NAME (First, Middle, Last) <b>EDGAR G. MEYER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GERTRUDE HIVICK</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MILDRED MEYER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>639 S. THIRD ST. OAKLAND, MD 21550</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>GARRETT MEMORIAL GARDENS</b>			DATE <b>5/3</b>		20c. LOCATION — City or Town, State <b>OAKLAND, MARYLAND</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>s/p CVA's - MULTIPLE</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>10 days</b> <b>hrs</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D15333</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/30/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS G. JOHNSON, M.D. 311 N. 4TH STREET OAKLAND, MD 21550</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 02 1996</b>		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14746

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET B. MCCOMAS</b>				2. Date of Death Month <b>5</b> Day <b>5</b> Year <b>96</b>		3. Time of Death <b>12:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>DORCHESTER GENERAL Hospital</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>579-38-2024</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 26, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
Usual Residence of Decedent								
10a. State <b>Maryland</b>			10b. County <b>Dorchester</b>			10c. City, Town or Location <b>Cambridge</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>15 Oak St.</b>			10f. Zip Code <b>21613</b>		
10g. Citizen of What Country? <b>U.S.A.</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry			17. Father's Name (First, Middle, Last) <b>Richard Earl Beall</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Lepha Neely</b>			19a. Informant's Name/Relationship (Type, Print) <b>George W. McComas / husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Oak St. Cambridge, MD 21613</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>			20c. Location - City or Town, State <b>5/6 Salisbury Maryland</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Thomas Funeral Home 700 Locust St. Cambridge, MD 21613</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>MONTHS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEPSIS, DEHYDRATION, HYPONATREMIA</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number <b>D22773</b>			29d. Date signed (Month, Day, Year) <b>5/5/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HUBERT L. FIELD MD 503 BYRN ST CAMBRIDGE MD 21613</b>								
31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 14747

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Junior Martin McRobie				2. DATE OF DEATH MONTH DAY YEAR May 10 1996		3. TIME OF DEATH 1350 M	
4. SOCIAL SECURITY NUMBER 219 14 6864		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 28 1925	
9a. FACILITY NAME (If not institution, give street and number) Garrett Co. Mem. Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Mt. Lake Park		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER PO Box 2121				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military Disabled		16b. KIND OF BUSINESS/INDUSTRY US Army			
17. FATHER'S NAME (First, Middle, Last) William Tylor Mc Robie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Winnie True			
19a. INFORMANT'S NAME (Type/Print) Brenda McRobie				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 2121 Mt. Lake Park, Md 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, date, time) Garrett Co Mem Gardens May 13 96		20c. LOCATION — City or Town, State Oakland, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock Funeral Home PO Box 523 Kitzmiller, Md 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction							
b. ASCV							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one)							
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Andrew E. France MD				29c. LICENSE NUMBER D07258		29d. DATE SIGNED (Month, Day, Year) May 12 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew E. France MD Oakland Md 21550							
31. DATE FILED (Month, Day, Year) MAY 15 1996				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended Line 11 JO  
FCHD

96 14748

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>CAROLINE LOUISE McNICKLE</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>23</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>11:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-56-8614</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 16, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6829 Plantation Road</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dictaphone Typist</b>		15b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Grover Cleveland Hastings</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jean Johnston</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thomas F. McNickle</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6829 Plantation Road, Frederick, Maryland 21701</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. DATE <b>4/26</b>		20d. LOCATION — City or Town, State <b>Rockville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>URINARY TRACT INFECTION with sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Extensive Left lower lobe pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>1 week</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>(R) CVA 11/93</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D21944</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/25/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James S. Grissom, MD 300 West Ninth Street, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14749

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARGARET LUSBY Mac Donald</b>						2. Date of Death Month Day Year <b>April 29, 1996</b>		3. Time of Death <b>4:00 Am</b>						
	4a. Facility Name (If not institution, give street and number) <b>10505 CEDARVILLE ROAD, #1-14</b>						4b. City, Town, or Location of Death <b>BRANDYWINE</b>		4c. County of Death <b>Prince George's</b>						
<b>Funeral Director</b>	5. Social Security Number <b>578-14-7617</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 9, 1913</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
	Usual Residence of Decedent														
10a. State <b>MARYLAND</b>			10b. County <b>PRINCE GEORGE'S</b>			10c. City, Town or Location <b>BRANDYWINE</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
10e. Street and Number <b>10505 CEDARVILLE ROAD, #1-14</b>						10f. Zip Code <b>20613</b>		10g. Citizen of What Country? <b>UNITED STATES</b>							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BANK TELLER</b>				16b. Kind of Business/Industry <b>BANKING</b>							
17. Father's Name (First, Middle, Last) <b>ALGSRON LUSBY</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MAGGIE S. HUNGERFORD</b>									
19a. Informant's Name/Relationship (Type, Print) <b>NORMA JEAN SHELLENBERGER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2821 HOMMETTE PLACE, WALDORF, MARYLAND 20601</b>									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON NATIONAL CEM., MAY 9, 1996 ARLINGTON, VA</b>				20c. Location - City or Town, State							
21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN M00053</b>						22. Name and Address of Facility <b>THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CORONARY Artery Disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>years (8+)</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mitral Valvular Heart Disease, Hypertension</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>[Signature] MD</b>		29c. License number <b>025925</b>		29d. Date signed (Month, Day, Year) <b>May 2, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. BERGER #205, 7720 Wisconsin Ave Bethesda Md 20814</b>										31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14750

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN G. MCGUIGAN</b>				2. Date of Death Month Day Year <b>April 27, 1996</b>		3. Time of Death <b>2:15 AM</b>											
	4e. Facility Name (If not institution, give street and number) <b>Bel Forest Nursing Home</b>				4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>											
Funeral Director	5. Social Security Number <b>215-34-1798</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/19/05</b>											
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Whiteford</b>											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>3006 Whiteford Road</b>		10f. Zip Code <b>21160</b>		10g. Citizen of What Country? <b>USA</b>											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry													
	17. Father's Name (First, Middle, Last) <b>George Andrew Grove</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah May Henry</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>Albert L. McGuigan</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3006 Whiteford Rd., Whiteford, MD 21160</b>													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Slate Ridge Cemetery</b>		Date <b>4/29/96</b>		20c. Location - City or Town, State <b>Delta, PA</b>											
	21. Signature of Funeral Service Licensee <i>John H. Tullott</i>				22. Name and Address of Facility <b>Harkins F.H. Inc., Delta, PA 17314</b>													
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Congestive Heart Failure.</b></td> <td>Approximate Interval Between Onset and Death <b>Five years</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Aortic Stenosis.</b></td> <td><b>Five years.</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure.</b>	Approximate Interval Between Onset and Death <b>Five years</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Aortic Stenosis.</b>	<b>Five years.</b>	c.		d.	
	Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure.</b>	Approximate Interval Between Onset and Death <b>Five years</b>															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Aortic Stenosis.</b>	<b>Five years.</b>																
	c.																	
	d.																	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease, Dementia.</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <i>Mark H. Wild MD</i>				29c. License number <b>235522</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mark Wild 2 North Ave Bel Air Maryland 21014</b>																		
31. Date filed (Month, Day, Year) <b>APR 30 1996</b>		32. Registrar's Signature <i>John Anderson Randall</i>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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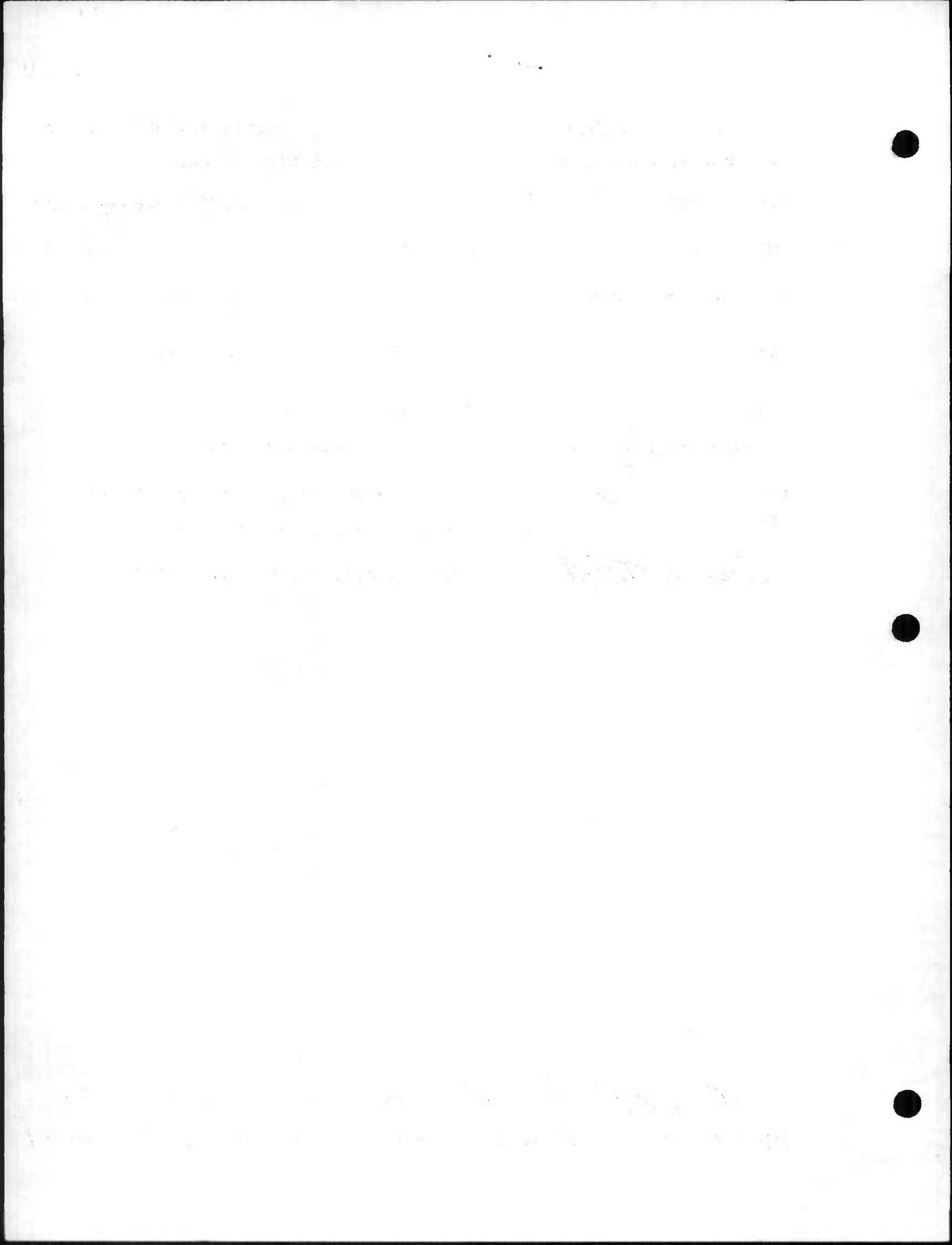
Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14751

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div style="display: flex; justify-content: space-between;"><span>Pauline</span><span>L.</span><span>Nell</span></div>					2. Date of Death Month Day Year April 23, 1996		3. Time of Death 4:26 pm			
	4a. Facility Name (If not Institution, give street and number) FREDERICK MEMORIAL HOSPITAL					4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK			
<b>Funeral Director</b>	5. Social Security Number 448-07-4936		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 7, 1915		9. Birthplace (State or Foreign Country) OKLAHOMA		
	Usual Residence of Decedent										
10a. State MARYLAND			10b. County CARROLL		10c. City, Town or Location MT. AIRY			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 907 N. MAIN STREET					10f. Zip Code 21771		10g. Citizen of What Country? UNITED STATES				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 4					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE			16b. Kind of Business/Industry HOSPITAL			
17. Father's Name (First, Middle, Last) PETER LANIG					18. Mother's Name (First, Middle, Maiden Surname) MARIA BAUER						
19a. Informant's Name/Relationship (Type, Print) H. MICHAEL NELL, SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 NORTH MAIN STREET, MT. AIRY, MD. 21771						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) LAYTONSVILLE CEMETERY		Data 4/27/96		20c. Location - City or Town, State LAYTONSVILLE, MD.				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038 LAYTONSVILLE, MD. 20882						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. ASCVD Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.										Approximate Interval Between Onset and Death years.	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number D35164		29d. Date signed (Month, Day, Year) 4/24/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW ZARICK, JR., M.D., 130 THOMAS JOHNSON DRIVE, FREDERICK, MD. 21702											
31. Date filed (Month, Day, Year) APR 29 1996			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14752

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Quentin Earl NORRIS, JR.				2. Date of Death Month April Day 24 Year 1996		3. Time of Death 7:20 am		
	4a. Facility Name (If not Institution, give street and number) 412 West "B" Street				4b. City, Town, or Location of Death Brunswick		4c. County of Death Maryland		
Funeral Director	5. Social Security Number 217-42-8960	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 1, 1944		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Knoxville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 18920 Sandy Hook Road				10f. Zip Code 21758		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry Phone Company		
	17. Father's Name (First, Middle, Last) Quentin Earl Norris, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Catherine Louise Lewis				
	19a. Informant's Name/Relationship (Type, Print) Julie Anne Oden - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 636 - Harpers Ferry, WV 25425				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brownsville Heights Cem.		Date 4/27		20c. Location - City or Town, State Brownsville, MD		
	21. Signature of Funeral Service Licensee Robert R. Roberts				22. Name and Address of Facility Eackles-Spencer Funeral Home - Harpers Ferry WV				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of head Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death SECONDS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Driveway							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Apr 24, 1996		28b. Time of Injury 7:20a M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject Shot self	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Vehicle in Driveway		28f. Location (Street and Number or Rural Route Number, City or Town, State) 412 W B Street Brunswick, Maryland			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Robert R. Roberts MD		29c. License number D09867		29d. Date signed (Month, Day, Year) 04/24/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert R.R. Roberts, M.D., 56 Thomas Johnson Drive, Frederick, Maryland 21702									
31. Date filed (Month, Day, Year) APR 26 1996		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14753

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VICTOR O STROW</b>				2. Date of Death Month <b>04</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>12:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1612 LEMONTREE LANE</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578-12-1185</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 5, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1612 LEMONTREE LANE</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>		16b. Kind of Business/Industry <b>FRUIT BASKET STORE</b>			
	17. Father's Name (First, Middle, Last) <b>MORRIS OSTROW</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>YETTA (UNAVAILABLE)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>OLGA B. OSTROW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1612 LEMONTREE LANE, SILVER SPRING, MD 20904</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEM GDNS</b>		Data <b>4/26/96</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VIRGINIA</b>	
	21. Signature of Funeral/Service Licensee <i>Lauren B. Mercer</i>				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION 5-10"</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY OCCLUSIVE THROMBOSIS 5-10"</b> Due to (or as a consequence of): <b>c. CORONARY ARTERIO SCLEROTIC DISEASE INDETERMINATE</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Lauren B. Mercer, MD</i>				29c. License number <b>009215</b>		29d. Date signed (Month, Day, Year) <b>04-24-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>10313 GEORGIA AVENUE, STE #207, SILVER SPRING, MD 20902</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature <i>John M. ...</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14754

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLE EIK OTTENSEN</b>				2. Date of Death Month Day Year <b>May 2 1996</b>		3. Time of Death <b>6:00 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>3627 Harmony Church Road</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>218-42-4423</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 18, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>Denmark</b>							
Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>3627 Harmony Church Road</b>				10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Physician</b>		16b. Kind of Business/Industry <b>Radiologist</b>		
17. Father's Name (First, Middle, Last) <b>Louis Ottesen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Else Marie Husum</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bodil Ottesen</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3627 Harmony Church Road, Havre de Grace, MD 21078</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc.</b>		Date <b>5/3/96</b>		20c. Location - City or Town, State <b>West Chester, PA</b>		
21. Signature of Funeral Service Licensee <b>Gary R. Di Giovanni</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic prostatic cancer</b> Dua to (or as a consequence of):  <b>b.</b> Dua to (or as a consequence of):  <b>c.</b> Dua to (or as a consequence of):  <b>d.</b>								Approximate Interval Between Onset and Death <b>5 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>William Ann Huber M.D. Ph.D.</b>				29c. License number <b>L2205</b>		29d. Date signed (Month, Day, Year) <b>May 02, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
31. Date filed (Month, Day, Year) <b>MAY 3 - 1996</b>				32. Registrar's Signature <b>J. A. Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14755

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Louise Elmore Orndorff</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 27, 1996</i>		3. TIME OF DEATH <i>4:45 A M</i>	
4. SOCIAL SECURITY NUMBER <i>093-48-6570</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>79</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 16, 1916</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Brunswick, MD</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Frederick Memorial Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Frederick</i>	
9c. COUNTY OF DEATH <i>Frederick</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Frederick</i>	
10c. CITY, TOWN OR LOCATION <i>Brunswick</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1100 Peach Orchard Drive</i>	
10f. ZIP CODE <i>21716</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>Housewife</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Adam McNeheies Orndorff</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lucy Irene Connor</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Patsy Rooney</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7 East "G" Street Brunswick, MD 21716</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hagerstown Crematory 4/29</i>		20c. LOCATION — City or Town, State <i>Hagerstown, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara A. Williams, Owner</i>				22. NAME AND ADDRESS OF FACILITY <i>John T. Williams Funeral Home Brunswick, MD 21716</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, History of bronchogenic adenocarcinoma of left upper lung</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Christopher Fleming, MD</i>				29c. LICENSE NUMBER <i>D37178</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-29-96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Christopher Fleming, MD 619 9th Ave Brunswick, Md 21716</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 01 1996</i>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14756

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley John Olszewski				2. Date of Death Month Day Year April 24, 1996		3. Time of Death 2:03 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-40-0955		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27, 1943	
	9. Birthplace (State or Foreign Country) Maryland		10e. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 798-B Wembley Dr.		10f. Zip Code 21701		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Property Management		16b. Kind of Business/Industry Apartment -management				
17. Father's Name (First, Middle, Last) Stanley J. Olszewski				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Sobul				
19a. Informant's Name/Relationship (Type, Print) (wife) Theresa Lafond Olszewski				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 798-B. Wembley Dr./ Frederick, Md. 21701				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial		20c. Location - City or Town, State 4-29-96 Frederick, Maryland				
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Ben A. Dwyer MD</i>				29c. License number D37501		29d. Date signed (Month, Day, Year) 4/26/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOYD A. DWYER MD 201 TOLL HOUSE AVE BLDG H-6 FREDERICK, MD 21701								
31. Date filed (Month, Day, Year) APR 29 1996				32. Registrar's Signature <i>John A. Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14757

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERTHA VIOLA OESTER

2. Date of Death  
Month Day Year

MAY 5 1996

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

213-72-3970

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 2, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Accident

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2329 Devil's Half Acre Road

10f. Zip Code

21520

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lloyd Handwerk

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Ringler

19a. Informant's Name/Relationship (Type, Print)

Viola Oester, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2329 Devil's Half Acre Road, Accident, MD 21520

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. John's, M.S.Cem. May 7, 1996

Date

20c. Location - City or Town, State

Accident, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275,  
179 Miller St., Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Renal Failure - Insufficiency

Due to (or as a consequence of):

b. Acute PANCREATIS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis  
Pyelonephritis  
UTERINE CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D23167

29d. Date signed (Month, Day, Year)

MAY 5 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Juan A. Arnsuero M.D. 902 Seton Drive, Cumberland, MD 21502.

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Amended Line 1 SD, FCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14758

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clark Allan Orem</b>				2. Date of Death Month <b>April</b> Day <b>19</b> Year <b>1996</b>				3. Time of Death <b>9:04 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-26-0585</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1930</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10f. Zip Code <b>21704</b>				10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+) +2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cab Driver</b>				16b. Kind of Business/Industry <b>Transportation</b>	
	17. Father's Name (First, Middle, Last) <b>Harry F. Orem, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Jordan Orem Carroll</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Beryl A. Orem</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5909 Bartonville Road Frederick, MD 21704</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Cemetery</b>		Date <b>4/25/96</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702</b>					
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Ventricular fibrillation</b> Due to (or as a consequence of): <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): <b>Coronary Artery Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>6 yrs</b>				Approximate Interval Between Onset and Death <b>minutes</b> <b>minutes</b> <b>6 yrs</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asthma</b> <b>Hypertension</b> <b>Diabetes Mellitus</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>April 19 '96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702</b>										
31. Date filed (Month, Day, Year) <b>APR 20 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14759

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOSEPH EDWARD POTTER, SR.

2. Date of Death

Month Day Year  
APRIL 30, 1996

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

3955 RAVINE DRIVE

4b. City, Town, or Location of Death

WHITE PLAINS

4c. County of Death

CHARLES

5. Social Security Number

270-14-1751

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 6, 1922

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WHITE PLAINS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3955 RAVINE DRIVE

10f. Zip Code

20695

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

MANUFACTURER REPRESENTATIVE

16b. Kind of Business/Industry

HEATING AND AIR/COND.

17. Father's Name (First, Middle, Last)

JOSEPH EDWARD POTTER

18. Mother's Name (First, Middle, Maiden Surname)

EVA MARIE NOLAN

19a. Informant's Name/Relationship (Type, Print)

MARY POTTER (SPOUSE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3955 RAVINE DRIVE WHITE PLAINS, MARYLAND 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. JOSEPHS CEMETERY

Date

MAY 4

20c. Location - City or Town, State

POMFRET, MARYLAND

21. Signature of Funeral Service Licensee

BENJAMIN M. MATTHEWS M-00658

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.  
P.O. BOX 156 WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Fibrinous of lung with Respiratory Failure  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accidental 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MAY 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATHEN PEMBROKE SQ. #104 WALDORF, MARYLAND 20603

31. Date filed (Month, Day, Year)

MAY 03 1996

32. Registrar's Signature

Julia Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14760

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KENNETH PARKS</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>27</b> YEAR <b>96</b>		3. TIME OF DEATH <b>0602</b> M	
4. SOCIAL SECURITY NUMBER <b>213-22-9759</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 3, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>	
9c. COUNTY OF DEATH <b>Dorchester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Dorchester</b>	
10c. CITY, TOWN OR LOCATION <b>Cambridge</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3012 Old Route 50</b>	
10f. ZIP CODE <b>21613</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painting Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home Improvement</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Joshua Parks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna E. Pritchett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Calvert Parks</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2407 Lakesville-Crapo Rd., Crapo, MD. 21626</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dorchester Mem. Pk. 4-30</b>		20c. LOCATION — City or Town, State <b>Cambridge, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  (IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. cerebrovascular accident</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D 47520</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/29/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HAMID BURNEY 10 AURORA STREET CAMBRIDGE, MD 21613</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 2 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14761

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN PLATER</b>				2. Date of Death Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b>				3. Time of Death <b>12:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>CLINTON</b>				4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>220-50-8526</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 19, 1945</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>Washington, D.C.</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. State		10b. County		10f. Zip Code <b>20001</b>				10g. Citizen of What Country? <b>USA</b>	
	10e. Street and Number <b>1301 Seven Street Northwest</b>									
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>				16b. Kind of Business/Industry <b>Dry Cleaning</b>	
	17. Father's Name (First, Middle, Last) <b>George H. Plater</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Hawkins</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Zimmerman- Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1213 Morse Street N.E. Washington, D.C. 20002</b>					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. Mary's Cemetery</b>		Date <b>May 3, 1996</b>		20c. Location - City or Town, State <b>Bryantown, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Lloyd M. Estep</b>				22. Name and Address of Facility <b>Adams Funeral Home Aquasco, Maryland 20608</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTI ORGAN FAILURE</b> Due to (or as a consequence of): <b>b. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of): <b>c. UNKNOWN</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEPSIS</b> <b>CUA, DEMENTIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>045435</b>		
				29d. Date signed (Month, Day, Year) <b>4/27/96</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SOUTHERN MARYLAND HOSPITAL</b>				31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>				32. Registrar's Signature <b>[Signature]</b>		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended item #'s 4,10,19b per F.D.  
5/6/96 Carroll Co. P.L.C.

State of Maryland / Department of Health and Mental Hygiene

96 14762

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

GEORGE PARRY

2. Date of Death

Month Day Year  
April 28, 1996

3. Time of Death

Approx 3:00pm

4a. Facility Name (If not institution, give street and number)

2309 Old Westminster Pike

4b. City, Town, or Location of Death

Finksburg

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

214-16-1656

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7-10-06

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedant

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2309 Old Westminster Pike  
2039

10f. Zip Code

21048

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Edgar Eugene Parry

18. Mother's Name (First, Middle, Maiden Surname)

Angelene Maude Nelson

19a. Informant's Name/Relationship (Type, Print)

Ann Parry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2309 Old Westminster Pike., Finksburg, MD 21048  
2039

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Saints Cemetery

Date

05/01/96

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

Katherine Pritts - Switzer

22. Name and Address of Facility

Pritts Funeral Home & Chapel  
412 Washington Rd., Westminster, MD 21157

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHF

Due to (or as a consequence of):

b. EMPHYSEMA

Due to (or as a consequence of):

c. Peripheral Vascular Insufficiency

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Age

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Renee Reim

29c. License number

B25804

29d. Date signed (Month, Day, Year)

4/30/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RENEE REIM MD 3125 BALTO BLVD FINKSBURG MD 21048

31. Date filed (Month, Day, Year)

MAY 01 1996

32. Registrar's Signature

Julia Switzer-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14763

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) M. Myrl Purcell				2. Date of Death Month Day Year April 29 1996		3. Time of Death 7:19 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-58-6448		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 29, 1902	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent				10c. City, Town or Location Kensington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. State Maryland		10b. County Montgomery		10e. Street and Number 4117 Franklin Street		10f. Zip Code 20895		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Jacob Phillips				18. Mother's Name (First, Middle, Maiden Surname) Rose Lillie				
19a. Informant's Name/Relationship (Type, Print) Myrilyn Barr				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10012 Crestwood Road, Kensington, Maryland 20895				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rockville Cemetery		20c. Location - City or Town, State 5/3/96 Rockville, Maryland		
21. Signature of Funeral Service Licensee Anchew J. Cole				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure 2 days Due to (or as a consequence of): b. ATRIAL Fibrillation 2 days Due to (or as a consequence of): c. arteriosclerosis old. Due to (or as a consequence of): d. Pulmonary Hypertension old.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Alzheimers Disease Severe Dementia.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Albert M. D.		29c. License number D31319		29d. Date signed (Month, Day, Year) 4-30-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto F. ALBIOL, MD 8218 Wisconsin Ave #105 Bethesda, MD.								
31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14764

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Ida Priscilla Poteet</u>				2. DATE OF DEATH MONTH DAY YEAR <u>April 27, 1996</u>		3. TIME OF DEATH <u>2:02 A</u> <sup>M</sup>	
4. SOCIAL SECURITY NUMBER <u>217-58-8468</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/10/1917</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>1307 West Jarrettsville Rd.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Forest Hill</u>		9c. COUNTY OF DEATH <u>Harford</u>	
10a. STATE <u>Md.</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Forest Hill</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1307 West Jarrettsville Rd.</u>				10f. ZIP CODE <u>21050</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>Housewife</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Walter L. Crowl</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hannah L. Iley</u>			
19a. INFORMANT'S NAME (Type/Print) <u>John H. Poteet, Jr.</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1307 W. Jarrettsville Rd. Forest Hill, Md. 21050</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Bel Air Memorial Gardens</u>		20c. LOCATION — City or Town, State <u>Bel Air, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Benjamin W. Kurtz</u>				22. NAME AND ADDRESS OF FACILITY <u>Jarrettsville, Md. 21084</u> <u>Kurtz Funeral Home P.O. Box 6</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>congestive heart failure</u> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <u>cardiomyopathy</u> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>46m</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>David S. Dunn</u>				29c. LICENSE NUMBER <u>D32297</u>		29d. DATE SIGNED (Month, Day, Year) <u>4 Apr 27, 1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DAVID S. DUNN 615 W. MAC PHEE</u>							
31. DATE FILED (Month, Day, Year) <u>APR 30 1996</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clara Marie Pyle</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 8 1996</b>		3. TIME OF DEATH 11:40 pm M	
4. SOCIAL SECURITY NUMBER <b>213 44 1216</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 4 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>W. Main St.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Kitzmiller</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Garrett</b>		10c. CITY, TOWN OR LOCATION <b>Kitzmiller</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>W. Main St.</b>				10f. ZIP CODE <b>21538</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Wm Hott</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Lee Rotruck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Vernon Pyle</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 628 Kitzmiller, MD 21538</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Kalbaugh Cemetery</b>		OATE <b>5 11 96</b>		20c. LOCATION — City or Town, State <b>Elk Garden W. Va</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Burdock</i>				22. NAME AND ADDRESS OF FACILITY <b>David A. Burdock Funeral Home</b> <b>PO Box 523 Kitzmiller, MD 21538</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASHD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></b>							Approximate Interval Between Onset and Death <b>12 months</b> <b>years</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 4 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas G. Johnson</i>				29c. LICENSE NUMBER <b>D15333</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 10 1996</b>				32. REGISTRAR'S SIGNATURE <i>John A. Burdock</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14766

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Walter Pearson</b>				2. Date of Death Month <b>April</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>1:27 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>5300 Spring Drive</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>		
Funeral Director	5. Social Security Number <b>220-32-1618</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 3, 1937</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Dorchester</b>	10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5300 Spring Drive</b>			10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-1990</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Military Reservist</b>		16b. Kind of Business/Industry <b>Government</b>				
	17. Father's Name (First, Middle, Last) <b>Robert Pearson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Thomas Ruark</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>wife</b> <b>Patricia Kaelin Pearson</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5300 Spring Drive, Cambridge, MD. 21613</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat. Cem. 5-9</b>		Data		20c. Location - City or Town, State <b>Arlington, VA.</b>		
	21. Signature of Funeral Service Licensee <i>John Brown Bromwell</i>			22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Cancer of Adrenal Cortex</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>			Approximate Interval Between Onset and Death <b>5 yrs</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>David E. Cowall</i>		29c. License number <b>026278</b>		29d. Date signed (Month, Day, Year) <b>5-2-96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David E. Cowall, M.D., 145 E. Carroll St., Salisbury, MD. 21801</b>									
31. Date filed (Month, Day, Year) <b>MAY 6 1996</b>			32. Registrar's Signature <i>Julia Davidson Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14767

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTHONY LLOYD QUEEN</b>				2. Date of Death Month <b>MAY</b> Day <b>1</b> Year <b>1996</b>		3. Time of Death <b>9:07 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>217-44-7626</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar. 12, 1946</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>228 West Edmonston Drive</b>			10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Parts Manager</b>		16b. Kind of Business/Industry <b>Business Equipment</b>			
	17. Father's Name (First, Middle, Last) <b>Warren Queen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Holmes</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Queen / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>228 West Edmonston Drive, Rockville, Maryland 20852</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		Date <b>5/3/96</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral Hemorrhage</b> Dua to (or as a consequence of): <b>b. Hypertension</b> Dua to (or as a consequence of): <b>c.</b> Dua to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>Days</b> <b>years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>		29c. License number <b>29453</b>		29d. Date signed (Month, Day, Year) <b>MAY 1 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALAN CHANACES 15215 SHADY GROVE RD ROCKVILLE MD 20850</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14768

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Thomas Redman</b>				2. Date of Death Month <b>Apr.</b> Day <b>30,</b> Year <b>1996</b>		3. Time of Death <b>4:10 pm</b>								
	4a. Facility Name (If not institution, give street and number) <b>The Althea Woodland Nursing Home</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>								
Funeral Director	5. Social Security Number <b>226-14-4190A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <b>AUGUST 8-16-1898</b>		9. Birthplace (State or Foreign County) <b>Virginia</b>						
	Usual Residence of Decedent														
10a. State <b>Md.</b>			10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>13211 Twinbrook Pkwy., Apt. 201</b>					10f. Zip Code <b>20851</b>		10g. Citizen of What Country? <b>U.S.A.</b>								
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Flag man</b>			16b. Kind of Business/Industry <b>State Highway</b>							
17. Father's Name (First, Middle, Last) <b>John H. Redman</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth White</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy R. Gehrman</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Md. 13211 Twinbrook Pkwy., Apt 201, Rockville,</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Round Hill Cemetery</b>			Date <b>5/4/96</b>		20c. Location - City or Town, State <b>King George, Va.</b>							
21. Signature of Funeral Service Licensee <b>E. m. Taliaferro</b>					22. Name and Address of Facility <b>Nash &amp; Slaw Funeral Home, King George, Va.</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiopulmonary Arrest</b> Due to (or as a consequence of): b. <b>Atrial Fibrillation</b> Due to (or as a consequence of): c. <b>Congestive Heart Failure</b> Due to (or as a consequence of): d.										Approximate interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred						
			28a. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>Gary W. Jones M.D.</b>		29c. License number <b>D30111</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Gary W. Jones M.D. 11305 Pitsea Dr Beltsville Md. 20705-1757</b>															
31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>					32. Registrar's Signature <b>Julia Hudson Randall</b>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

John F. Johnson  
The Atlantic Publishing House  
675-1000 00 00

Mr. Johnson  
The Atlantic Publishing House  
675-1000 00 00

John F. Johnson  
The Atlantic Publishing House  
675-1000 00 00

John F. Johnson  
The Atlantic Publishing House  
675-1000 00 00

John F. Johnson  
The Atlantic Publishing House  
675-1000 00 00

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State of Maryland / Department of Health and Mental Hygiene

96 14769

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Amber Rivera</b>				2. Date of Death Month <b>April</b> Day <b>30</b> Year <b>1996</b>				3. Time of Death <b>1240PM</b>						
	4a. Facility Name (If not Institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore city</b>				4c. County of Death						
Funeral Director	5. Social Security Number <b>176-76-6284</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>6</b> Months <b>19</b>		8. Date of Birth (Month, Day, Year) <b>Oct 11, 1995</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>Pennsylvania</b>		10b. County <b>York</b>		10c. City, Town or Location <b>Hanover</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number <b>2872 Baltimore Pike</b>				10f. Zip Code <b>17331</b>		10g. Citizen of What Country? <b>USA</b>								
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>N/A</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>				18b. Kind of Business/Industry <b>N/A</b>						
	17. Father's Name (First, Middle, Last) <b>Manuel Joseph Rivera</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Karen Teresa Preston</b>										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Manuel Joseph Rivera</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2872 Baltimore Pike, Hanover, PA 17331</b>										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hampstead Cemetery</b>		Date <b>5/3</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>								
	21. Signature of Funeral Service Licensee <b>Steve Eline</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St, Hampstead, MD 21074</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Werdnig-Hoffmann</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate interval Between Onset and Death <b>6 months</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Diane C Lipscomb MD</b>		29c. License number <b>M5637</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1996</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Diane C Lipscomb MD The Johns Hopkins Hospital, Baltimore MD</b>										31. Date filed (Month, Day, Year) <b>MAY 06 1996</b>		32. Registrar's Signature <b>John Anderson-Kadell</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14770

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas F. Rafter, Jr.

2. Date of Death

Month  
April

Day

Year

26 1996

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

2306 Pinneberg Avenue

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

189-12-4572

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3/12/22

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2306 Pinneberg Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

geologist

16b. Kind of Business/Industry

American Geophysical  
Union

17. Father's Name (First, Middle, Last)

Thomas F. Rafter, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna McLaughlin

19a. Informant's Name/Relationship (Type, Print)

Audra B. Rafter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2306 Pinneberg Ave. Rockville, MD 20851

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Crematory

Date

4/28/96

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on this line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Gastric Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 33293

29d. Date signed (Month, Day, Year)

4/28/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith 5401 Western Ave. N.W. Washington D.C. 20015-2998

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14771

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann Marie Ralph</b>				2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>7:05PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>145-14-2896</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 12, 1924</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>104 Monroe Street #101</b>				10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4or 5+)</b> <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		18b. Kind of Business/Industry <b>U.S. Government</b>			
17. Father's Name (First, Middle, Last) <b>Edward A. Gaughin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Marie Newell</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Michele D. DuBois/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Monroe St., #101 Rockville, Maryland 20850</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		Date <b>April 27, 1996</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Ralph</b> M00198				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral Herniation</b> Due to (or as a consequence of): <b>b. Intracerebral Hemorrhage</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D40353</b>		29d. Date signed (Month, Day, Year) <b>4/25/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Van, MD 5530 Wisconsin Ave, #1053 Chevy Chase, MD 20815</b>									
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature <b>[Signature]</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14772

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Rogala</b>				2. Date of Death Month <b>4</b> Day <b>27</b> Year <b>96</b>		3. Time of Death <b>9 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2310 Washington Ave</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>214-30-0949</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Lask, Poland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>2310 Washington Avenue</b>		10f. Zip Code <b>20815</b>	
	10g. Citizen of What Country? <b>U. S. A.</b>				11. Marital Status <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>3rd Grade</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Men's Clothing &amp; Formal Wear</b>				16b. Kind of Business/Industry <b>Owner - Mike's Formal Wear</b>		17. Father's Name (First, Middle, Last) <b>Shlomo Rogala</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Fayga (Unascertainable)</b>				19. Informant's Name/Relationship (Type, Print) <b>Frances F. Rogala</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2203 Washington Avenue, # 202, Silver Spring, Md. 20910</b>	
	20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		20c. Location - City or Town, State <b>Olney, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Donald C. Stettinmyer</b>				22. Name and Address of Facility <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease 5 years</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Peripheral Vascular Disease</b> <b>Cerebrovascular Accidents</b>							
	23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. Date of Injury (Month/Day/Year) <b>N/A</b>		28b. Time of Injury <b>N/A</b> M	
	28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b>N/A</b>			
	28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) <b>N/A</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
	29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
Physician /Medical Examiner	29b. Signature and title of certifier <b>Michael J. Schwartz MD</b>				29c. License number <b>D25144</b>		29d. Date signed (Month, Day, Year) <b>4/27/96</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael J. Schwartz MD 4915 Auburn Ave Bethesda Md.</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature <b>Juli Anderson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14773

Reg. No.

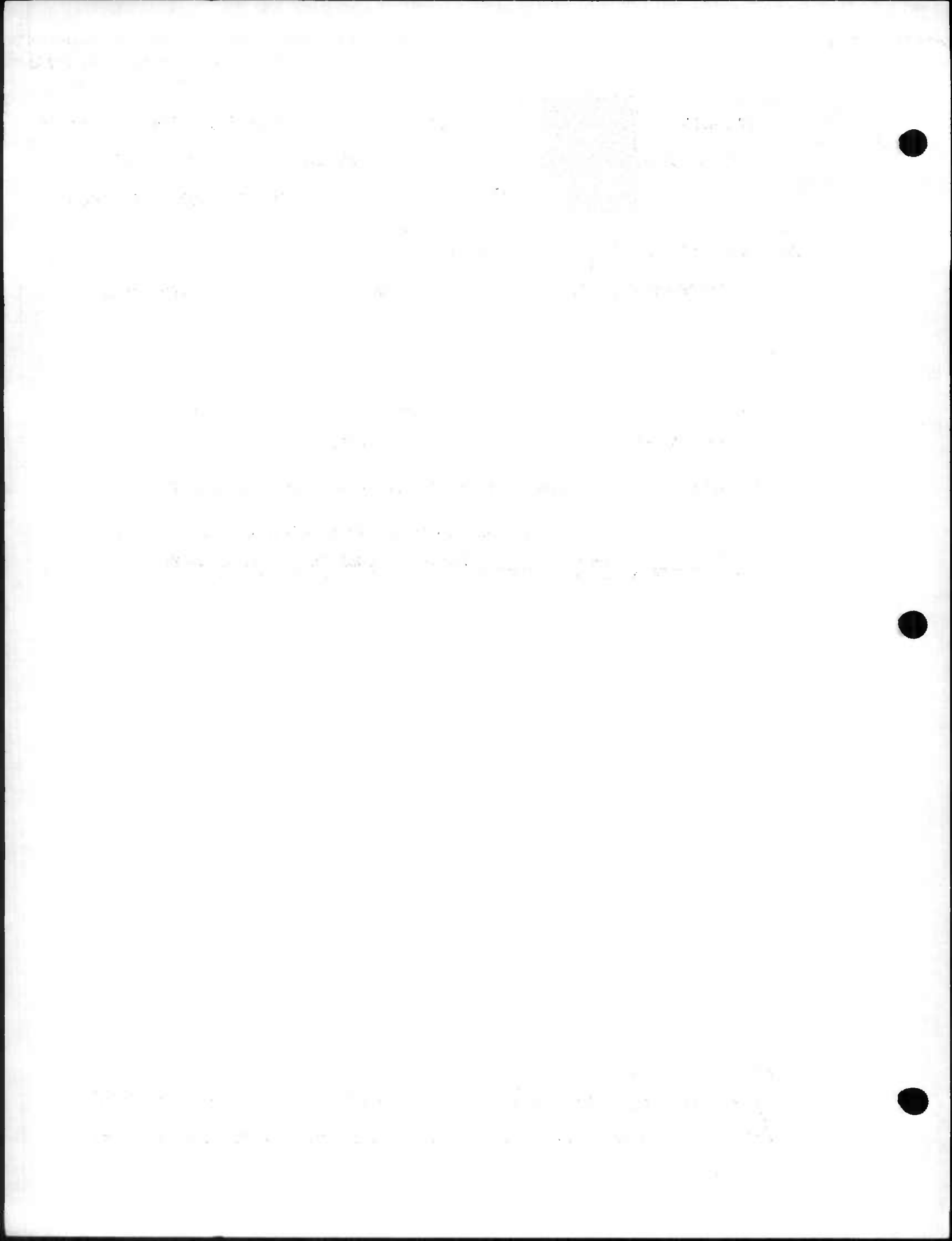
<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>LORRAINE ROSEN</b>				2. Date of Death Month Day Year <b>APRIL 23, 1996</b>		3. Time of Death <b>8:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9 REACH COURT</b>				4b. City, Town, or Location of Death <b>POTOMAC</b>		4c. County of Death <b>MONTGOMERY</b>	
<b>Funeral Director</b>	5. Social Security Number <b>352-09-0419</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 31, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>							
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent							
	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PIKESVILLE</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>7 SLADE AVENUE #713</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES MANAGER</b>			16b. Kind of Business/Industry <b>ENCYCLOPEDIA</b>		
	17. Father's Name (First, Middle, Last) <b>JOSEPH WALLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN LEVIN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARK ROSEN (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 REACH COURT - POTOMAC, MARYLAND 20854</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS 4/25/96</b>		20c. Location - City or Town, State <b>OLNEY, MARYLAND</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Adenocarcinoma of the Right Lung</b></p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>2 1/2 years</b></p> </div> </div>							

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar  
 DHMH 16 Rev 6/95






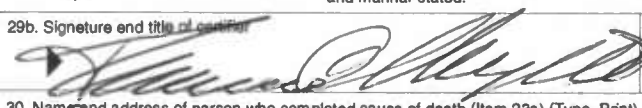
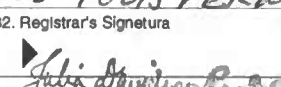
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14774

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KOUCHUCK</b>				2. Date of Death Month <b>April</b> Day <b>23</b> Year <b>1996</b>				3. Time of Death <b>9:25 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>7636 Westlake Terrace</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>218-02-0142</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>Aug. 04, 1926</b>				9. Birthplace (State or Foreign Country) <b>Iran</b>						
Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>7636 Westlake Terrace</b>				10f. Zip Code <b>20817</b>				10g. Citizen of What Country? <b>Iran</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Owner</b>				16b. Kind of Business/Industry <b>Rug Import</b>			
17. Father's Name (First, Middle, Last) <b>Aman Roshanian</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Leily Roshanian</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Leila Roshanian</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7636 Westlake Terrace, Bethesda, Maryland 20817</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 04-27-96</b>		Data		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
21. Signature of Funeral Service Licensee  <b>M00956</b>				22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION ACUTE</b> Due to (or as a consequence of): <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CHRONIC</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number <b>207099</b>				29d. Date signed (Month, Day, Year) <b>APRIL 24 96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS C MAYOR 10127 FARMWOOD RD BETHESDA MD 20817</b>											
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14775

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilton E. Ramsey				2. Date of Death Month Day Year April 26 96		3. Time of Death 1755		
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 221-03-9917		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) June 23, 1913		
	9. Birthplace (State or Foreign Country) PA		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
Usual Residence of Decedent				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		17. Kind of Business/Industry Greenhill Dairy	
10a. State MD				10b. County Cecil		10c. City, Town or Location Elkton		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 135 Blair Lane				10f. Zip Code 21921		10g. Citizen of What Country? USA		14. Race - American Indian, Black, White, etc. Specify: white	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		17. Kind of Business/Industry Greenhill Dairy		18. Mother's Name (First, Middle, Maiden Surname) Viola Vandever	
17. Father's Name (First, Middle, Last) Alfred Ramsey				18. Mother's Name (First, Middle, Maiden Surname) Viola Vandever		19. Informant's Name/Relationship (Type, Print) Lillian Ramsey (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Blair Lane Elkton, MD 21921	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Silverbrook Cemetery		20c. Location - City or Town, State Wilm., De.		20d. Date 4/30/96	
21. Signature of Funeral Service Licensee <i>Nicholas...</i>				22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., De. 19803		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Myocardial Infarction Due to (or as a consequence of): b. Congestive Heart failure Due to (or as a consequence of): c. Lung Carcinoma with metastasis Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hour 1 week 2 years		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Myocardial Infarction Due to (or as a consequence of): b. Congestive Heart failure Due to (or as a consequence of): c. Lung Carcinoma with metastasis Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hour 1 week 2 years				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>M.H. M.D.</i>		29c. License number 042211		29d. Date signed (Month, Day, Year) April 30, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID GAR-EI M.D. 3 MAULDIN AVE North East, Md 21901				31. Date filed (Month, Day, Year) MAY 01 1996		32. Registrar's Signature <i>Julia...</i>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14776

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Ruth Royer				2. Date of Death Month Day Year April 29, 1996		3. Time of Death 4:20 pm	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-20-0194	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 15, 1927	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5935 Quinn Road			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 8			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly		16b. Kind of Business/Industry Optical Company		
	17. Father's Name (First, Middle, Last) Leslie Guy GROSS				18. Mother's Name (First, Middle, Maiden Surname) Elsie Grace HEFFNER			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara A. Grimes/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5928 Quinn Road, Frederick, Maryland 21701			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens May 2, 1996		Data		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee <i>Kathleen Roberson</i> MO0706				22. Name and Address of Facility Keeney & Basford Funeral Home 106 E Church Street, Frederick, Maryland 21701			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Interstitial Pulmonary Fibrosis</u> Due to (or as a consequence of): b. <u>Respiratory infection</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Approximate interval between Onset and Death 3-4 yr 4-5d.							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>chronic obstructive pulmonary disease</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>A Meyerhoff MD</i>				29c. License number D 43408		29d. Date signed (Month, Day, Year) 4/29/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Meyerhoff MD 300 W 9th St Frederick, MD							
31. Date filed (Month, Day, Year) APR 30 1996		32. Registrar's Signature <i>Johi Shuler-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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96 14777

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gladys Lucille RANNEBERGER				2. DATE OF DEATH MONTH DAY YEAR April 21, 1996		3. TIME OF DEATH 12:45 P.M.	
4. SOCIAL SECURITY NUMBER 220-34-0751		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 21, 1996	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 400 North Avenue				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Martin Luther Cordell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Meitzler			
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy M. Ranneberger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4829 Mt. Zion Road, Frederick, MD 21703			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frederick Memorial Park, April 24, 1996		20c. LOCATION — City or Town, State Frederick, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H Ruby M00703		22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Atherosclerotic Heart Disease</u> years							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nonlethal 4 <input type="checkbox"/> Nonlethal		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Casper E. Cline, III, M.D.				29c. LICENSE NUMBER D16428		29d. DATE SIGNED (Month, Day, Year) April 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) APR 23 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 14778

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOTTIE FOX RUBY				2. DATE OF DEATH MONTH DAY YEAR APRIL 20, 1996		3. TIME OF DEATH 11:00 A. M	
4. SOCIAL SECURITY NUMBER 215-09-0625		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 2, 1897	
9a. FACILITY NAME (If not institution, give street and number) ST. CATHERINE'S NURSING CENTER				9b. CITY, TOWN OR LOCATION OF DEATH EMMITSBURG		9c. COUNTY OF DEATH FREDERICK	
10a. STATE MARYLAND		10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION EMMITSBURG		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 29 W. MAIN ST.				10f. ZIP CODE 21727		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RECONDITIONER		17. KIND OF BUSINESS/INDUSTRY MONTGOMERY WARD CO.			
17. FATHER'S NAME (First, Middle, Last) EDWARD FOX				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA HOUCK			
19a. INFORMANT'S NAME (Type/Print) ROBERT G. MYERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 W. MAIN ST., EMMITSBURG, MD. 21727			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) ELIAS LUTHERAN CEMETERY 4/23/96		20c. LOCATION — City or Town, State EMMITSBURG, MD. 21727			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Skiles</i>				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Atherosclerosis</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetic</i> <i>Osteoporosis</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan Carroll</i>				29c. LICENSE NUMBER D18205		29d. DATE SIGNED (Month, Day, Year) APRIL 20, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN CARROLL, M.D. 310 S. SETON AVE., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) APR 23 1996				32. REGISTRAR'S SIGNATURE <i>John D. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14779

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Albert Rosen				2. DATE OF DEATH MONTH DAY YEAR May 12, 1996		3. TIME OF DEATH 2:45 A. M	
4. SOCIAL SECURITY NUMBER 161-18-7290		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 20, 1918	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania							
9a. FACILITY NAME (If not institution, give street and number) 10450 Lottsford Road				9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville		9c. COUNTY OF DEATH Prince George	
10a. STATE MD		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Mitchellville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10450 Lottsford Road				10f. ZIP CODE 20721		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Psychologist		16b. KIND OF BUSINESS/INDUSTRY Mental Health	
17. FATHER'S NAME (First, Middle, Last) Moses Rosen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosie Prager			
19a. INFORMANT'S NAME (Type/Print) Lauren Sharp				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1099 Whitchurch Court, Wheaton, IL 60187			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Comfort Crematory 5/13/96		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ewin Thomas Roun...</i>				22. NAME AND ADDRESS OF FACILITY Affordable Funeral Services 9929 Murnane Street, Vienna, VA 22181			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Lymphoma DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D19431		29d. DATE SIGNED (Month, Day, Year) May 12, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Ryan, M.D. 6189 Oxon Hill Road, Oxon Hill, MD 20745							
31. DATE FILED (Month, Day, Year) MAY 17 1996		32. REGISTRAR'S SIGNATURE <i>Johi Duckworth Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

et, " "

96 14780

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERTHA JANE RIGGLEMAN</b>				2. DATE OF DEATH MONTH <b>05</b> -DAY <b>10</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>236-64-8157</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>02-13-1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>		9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>W.V.</b>		10b. COUNTY <b>PRESTON</b>		10c. CITY, TOWN OR LOCATION <b>TERRA ALTA</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>154 HIGHLAND AVE.</b>				10f. ZIP CODE <b>26764</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+) <b>0</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>		15b. KIND OF BUSINESS/INDUSTRY <b>FOOD SERVICE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WALTER WHITTAKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EFFIE LEATHERMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLARD RIGGLEMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>154 HIGHLAND AVE., TERRA ALTA, WV 26764</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OAK GROVE CEM. 05-12-96</b>		20c. LOCATION — City or Town, State <b>TERRA ALTA, WV</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Marked Appeal</i>				22. NAME AND ADDRESS OF FACILITY <b>ARTHUR H WRIGHT FUNERAL HOME 105 HIGHLAND AVE. TERRA ALTA, WV</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>12705</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>603B W. State Avenue Terra Alta, WV 26764 (Roger A. Lewis, M.D.)</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 13 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14781

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIVIAN M. RECKLEY				2. Date of Death Month Day Year May 3, 1996		3. Time of Death 9:35 A.M.	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 220-46-4194		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) June 15 1910	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Allegany		10c. City, Town or Location Westernport	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 219 Hammond St.		10f. Zip Code 21562		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Jack E. Baldwin				18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Klencke			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Raymond S. Parker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Creek, Wv. 26743			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery		20c. Location - City or Town, State Westernport, Md.		20d. Date 5-6-96	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Wayne Boal				22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of liver Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 weeks
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier Sunil Gupta
2	29c. License number D 33280		29d. Date signed (Month, Day, Year) May 5th, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta, M.D., 625 Kent Ave., Cumberland, Md. 21502			
	31. Date filed (Month, Day, Year) MAY 08 1996		32. Registrar's Signature John Anderson					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14782

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES B. SNAPP III					2. Date of Death Month Day Year MAY 12 1996		3. Time of Death 5:15 PM					
	4e. Facility Name (If not institution, give street and number) WILSON HEALTH CARE CENTER					4b. City, Town, or Location of Death GAITHERSBURG		4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 216-01-5188		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 19, 1915		9. Birthplace (State or Foreign Country) MARYLAND				
	Usual Residence of Decedent									10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location GAITHERSBURG								
	10e. Street and Number 301 RUSSELL AVENUE				10f. Zip Code 20877		10g. Citizen of What Country? UNITED STATES						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LETTER CARRIER				16b. Kind of Business/Industry POSTAL SERVICE						
	17. Father's Name (First, Middle, Last) CHARLES B. SNAPP, JR.					18. Mother's Name (First, Middle, Maiden Surname) ROSE H. BOUCHAT							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PHILIP L. SNAPP					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 E. ACADEMY ST., FUQUAY-VARINA, N. C. 27526							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 5/13/96		20c. Location - City or Town, State ALEXANDRIA, VIRGINIA						
	21. Signature of Funeral Service Licensee Muriel H. Barber					22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MARYLAND 20882							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Recurrent cerebral vascular accident with hemiparesis b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 3 weeks			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Type 2 Hypertension Multi-infarct dementia									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier H. Robert Birschbach		29c. License number 04115		29d. Date signed (Month, Day, Year) MAY 13 1996							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. ROBERT BIRSCHBACH, M.D. 6320 DEMOCRACY BLVD., BETHESDA, MD. 20817										31. Date filed (Month, Day, Year) MAY 20 1996		32. Registrar's Signature John Andrew Ruffell	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14783

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Haugh Simmons				2. Date of Death Month Day Year May 2 1996		3. Time of Death 2:40	
	4a. Facility Name (If not institution, give street and number) 841 FSK Highway,				4b. City, Town, or Location of Death Keymar		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 216-05-6507		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) July 2, 1913	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Keymar	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 841 FSK Highway		10f. Zip Code 21757		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Service			
	17. Father's Name (First, Middle, Last) S. Edward Haugh				18. Mother's Name (First, Middle, Maiden Surname) Effie Ellen Bohn			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert C. Simmons, Jr. Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 FSK Highway, Keymar, MD 21757			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Haugh's Church Cemetery		20c. Date May 5		20d. Location - City or Town, State Ladiesburg, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee J. Keir Skiles				22. Name and Address of Facility Skiles Funeral Home 136 E. Baltimore St. Taneytown, MD 21787			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatic Failure Due to (or as a consequence of): b. metastatic squamous cell carcinoma (rectum) ~ 8 mos Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death ~ 6 mos			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Jason A. Tate				29c. License number D 43643		29d. Date signed (Month, Day, Year) 5/3/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason A. Tate, MD 1 Kings Drive, Taneytown, MD 21787							
State Registrar	31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature D. Anderson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Certificate of Death

Reg. No.

96 14784

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RALPH JULIUS SCHLESINGER</b>				2. Date of Death Month <b>MAY</b> Day <b>1</b> Year <b>96</b>		3. Time of Death <b>4:05PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>DOCTOR'S HOSPITAL</b>				4b. City, Town, or Location of Death <b>LANHAM</b>		4c. County of Death <b>PRINCE GEORGE'S</b>	
Funeral Director	5. Social Security Number <b>155-24-5054</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC. 11, 1931</b>	9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>UNIVERSITY PARK</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4206 COLLEGE HEIGHTS DRIVE</b>				10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREA</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANICAL ENGINEER</b>		16b. Kind of Business/Industry <b>WASTE WATER TREATMENT</b>		
17. Father's Name (First, Middle, Last) <b>EUGENE SCHLESINGER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAGDA TEITELBAUM</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BETTY SCHLESINGER (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4206 COLLEGE HEIGHTS DRIVE-UNIVERSITY PARK, MD. 20782</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GDN.</b>		Date <b>5/3/96</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VIRGINIA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>Seconds</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>MAY 1, 1996</b>		28b. Time of Injury <b>3:50PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <b>Fall</b>
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Corner WAKEFOREST + GUILFORD,</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>COLLEGE PARK, MD.</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D40324</b>		29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERRY A. JODRIE, MD #205, 7720 WISCONSIN AVE, BETHESDA, MD 20814</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14785

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Todd William Shenkыр				2. Date of Death Month Day Year April 28, 1996		3. Time of Death 3:15 PM		
	4a. Facility Name (If not institution, give street and number) 915 Clopper Road, #T-3				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 212-64-7329		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 16, 1961	9. Birthplace (State or Foreign Country) Arkansas	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 915 Clopper Road, #T-3				10f. Zip Code 20878		10g. Citizen of What Country? United States			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Electrical Company			
17. Father's Name (First, Middle, Last) Douglas William Shenkыр					18. Mother's Name (First, Middle, Maiden Surname) Bernadette Slitzke				
19a. Informant's Name/Relationship (Type, Print) Douglas & Bernadette Shenkыр					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13533 Turkey Branch Parkway, Rockville, MD 20853				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 4-29-96		20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee Green H. Rapp					22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Extreme Cachexia & Malnutrition Due to (or as a consequence of): b. Acquired Immunodeficiency Syndrome Due to (or as a consequence of): c. HIV Infection Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 months 1 yr. 4 mos. 2 yr. 6 mos.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cytomegalovirus Retinitis Pneumocystis Pneumonia (in past) Extensive Weeping Skin Ulcers (not KS)						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Katharine Waldmann, MD					29c. License number D08818		29d. Date signed (Month, Day, Year) April 29, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katharine Waldmann, M. D., 2000 Dennis Avenue, Silver Spring, MD 20902									
31. Date filed (Month, Day, Year) APR 30 1996			32. Registrar's Signature John D. Walker						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





96 14786

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA R. SNYDER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 23, 1996</b>		3. TIME OF DEATH <b>5:44 p M</b>	
4. SOCIAL SECURITY NUMBER <b>579-34-8884</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 21, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>10726 St. Margaret's Way</b>	
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) <b>2 Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dance Instructor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dancing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Josef Yakerson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Judith (Unascertainable)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Samuel S. Snyder, Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10726 St. Margaret's Way Silver Spring, Maryland 20902</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Cemetery 4/25/1996</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stottmeyer</b>				22. NAME AND ADDRESS OF FACILITY <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W. WASHINGTON, D.C. 20012-2095</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
<b>PNEUMONIA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
<b>Respiratory Distress Syndrome</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>C. Caldwell Ph.D.</b>				29c. LICENSE NUMBER <b>D43496</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MOHAMMAD KHALID MD 8830 CAMERON STREET SILVER SPRING</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-R...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

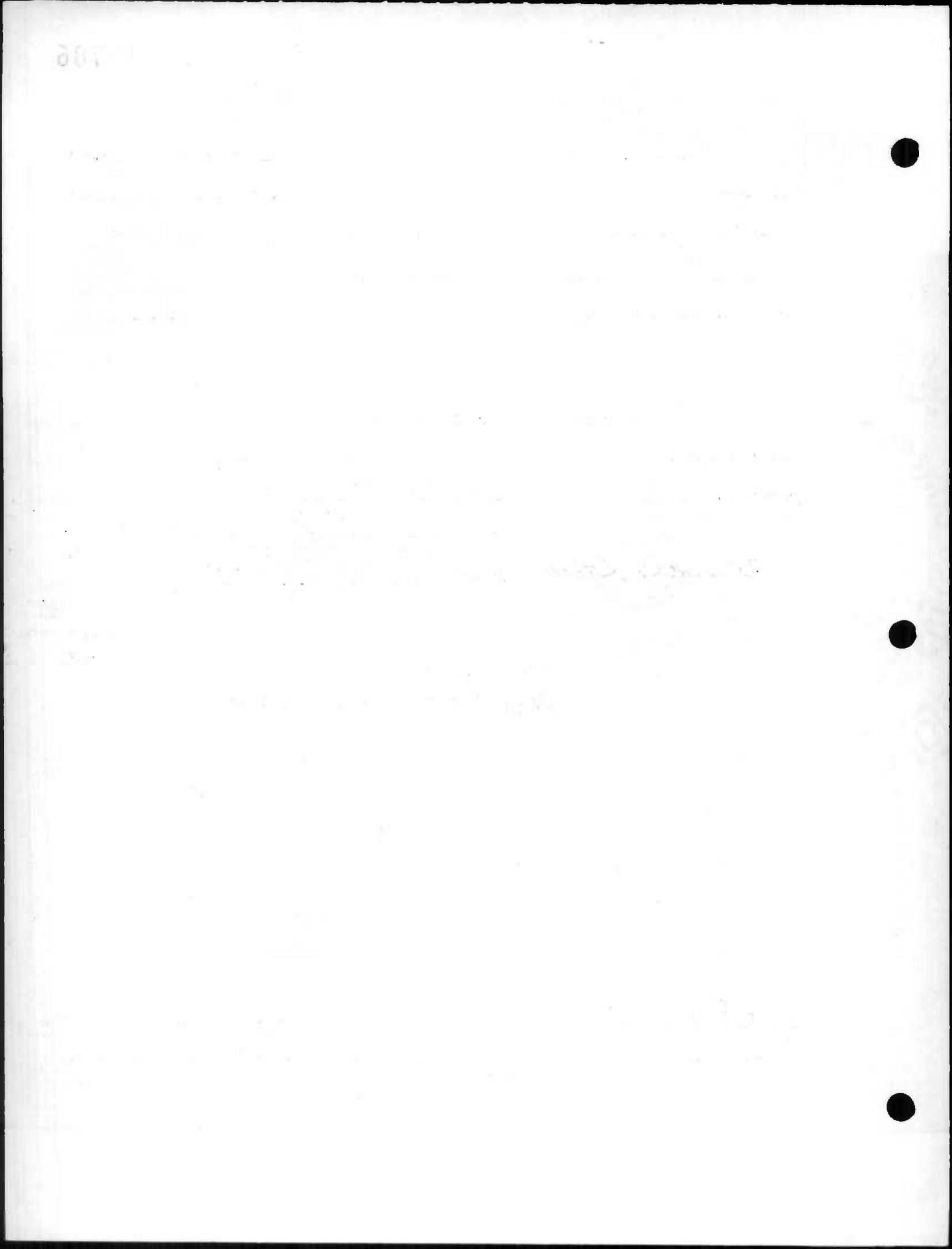
P.D.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14787

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALVIN RUDOLPH SANDERS</b>				2. Date of Death Month Day Year <b>APRIL 24 1996</b>		3. Time of Death <b>2:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>242 60 4960</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 6, 1939</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>16400 Cambridge Ct.</b>			
	10f. Zip Code <b>20715</b>				10g. Citizen of What Country? <b>United States</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>P.G. County Public Sch.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Odie Sanders</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothea Campbell</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Vera R. Sanders</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16400 Cambridge Ct., Bowie, Maryland 20715</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Memorial Cem. 4/30/96</b>		20c. Location - City or Town, State <b>Portsmouth, VA.</b>		21. Signature of Funeral Service Director <i>[Signature]</i>	
	22. Name and Address of Facility <b>McGuire Funeral Service Inc.</b>		22. Name and Address of Facility <b>7400 Georgia Ave., N.W., Washington, D.C. 20012</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of): <b>b. LEUKOPENIA</b> Due to (or as a consequence of): <b>c. CHE</b> Due to (or as a consequence of): <b>d. SMALL CELL CARCINOMA OF LUNG</b>		Approximate Interval Between Onset and Death <b>4 DAYS</b> <b>4 DAY</b> <b>1 YEAR</b> <b>1 YEAR</b>	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>DO0574</b>		29d. Date signed (Month, Day, Year) <b>APRIL 24, 1996</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Norman K. Bonner, MD 3231 SUPERIOR LANE Bowie, MD 20715</b>				31. Data filed (Month, Day, Year) <b>APR 30 1996</b>			
	32. Registrar's Signature <i>[Signature]</i>				33. Registrar's Title <b>John Davidson</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14788

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Morris Schneider</b>				2. Date of Death Month <b>April</b> Day <b>27</b> Year <b>1996</b>		3. Time of Death <b>12:35 Am</b>		
	4e. Facility Name (If not institution, give street and number) <b>Manor Care Fernwood</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>076-28-3996</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 29, 1908</b>		
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>6311 Maiden Lane</b>		10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Hardware</b>		17. Father's Name (First, Middle, Last) <b>Herman Schneider</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gussie Klugman</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Howard Schneider/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6311 Maiden La. Bethesda MD 20817</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Beth David Cemetery</b>		20c. Location - City or Town, State <b>Elmont, NY</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Edward Sagel Funeral Direction</b> <b>1091 Rockville Pike Rockville MD 20852</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>END STAGE DEMENTIA</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ABDOMINAL HERNIA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D35791</b>		29d. Date signed (Month, Day, Year) <b>4/30/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>M. Vemury 9801 GEORGIA AVE Silver SPRING MD 20906</b>		31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14789

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Joseph Schultz

2. Date of Death

April 28, 1996

3. Time of Death

2:20 A.M.

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

146-01-2940

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 23, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

403 Russell Avenue,

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Charles Schultz

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Kuhn

19a. Informant's Name/Relationship (Type, Print)

Veronica H. Schultz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 Russell Avenue, Gaithersburg, Maryland 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

4/29/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, Maryland 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Multi Infarct Dementia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 20516

29d. Date signed (Month, Day, Year)

April 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel R. Schulman, 9410 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

MAY 02 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

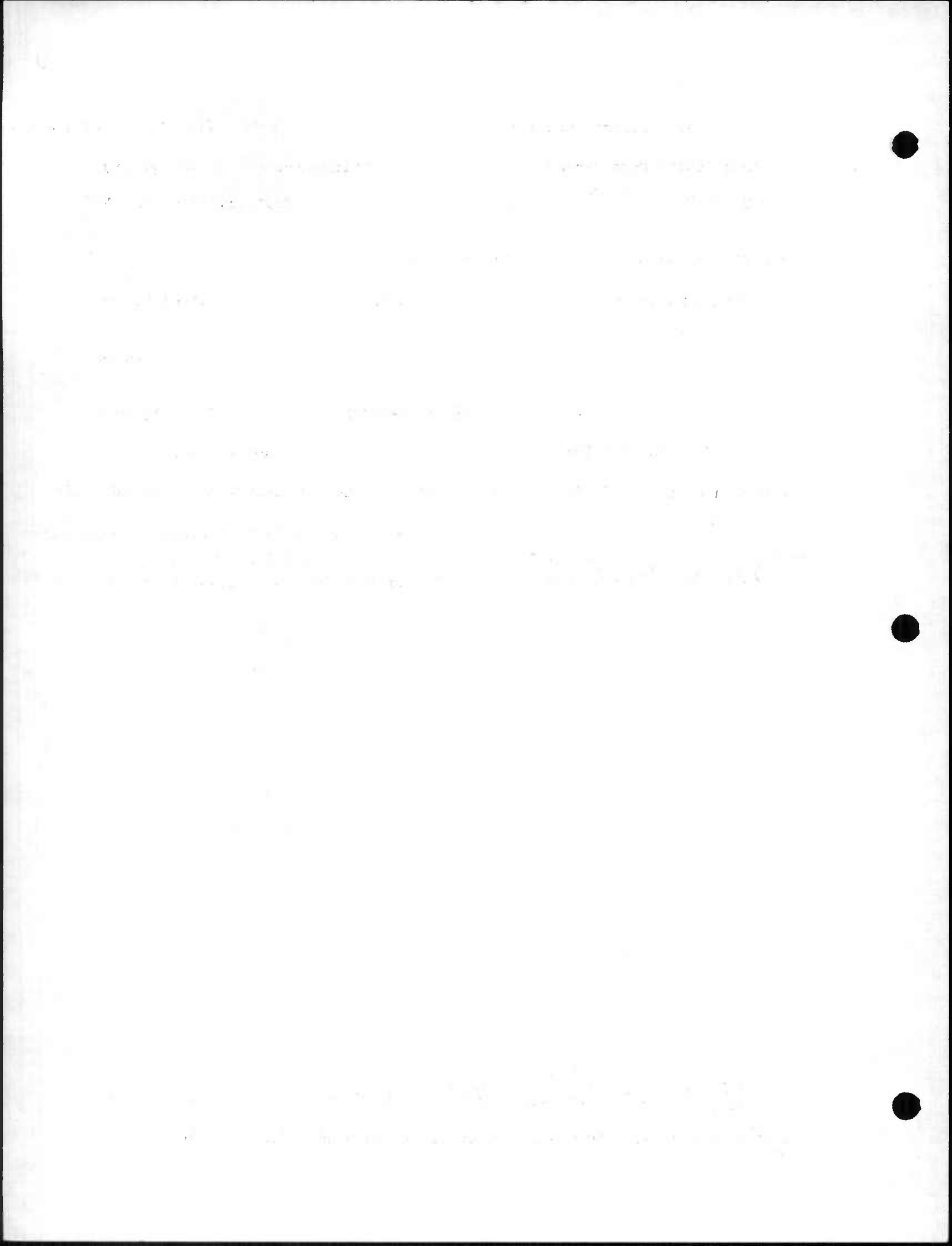
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland Department of Health and Mental Hygiene  
Certificate of Death

96 14790

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Lucille Smith</b>				2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>8:32 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bel Air Nursing and Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>214-03-9331</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1911</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>814 Giles Street</b>				10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Residential</b>		
17. Father's Name (First, Middle, Last) <b>Edward Palmer Rabbitt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie Gill</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Beauregard, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>406 Quail Hollow Drive, Forest, Virginia 24551</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens 5/2</b>		Date		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Madelyn Mitchell Shant</i>				22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>terminal dilated cardiomyopathy</b></p> <p>Due to (or as a consequence of):</p> <p><b>coronary artery disease</b></p> <p>Due to (or as a consequence of):</p> <p><b>atherosclerosis</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes, depression, ventricular arrhythmia, azotemia</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Hong Sun (Kim, M.D.)</b>						
29c. License number <b>D37364</b>		29d. Date signed (Month, Day, Year) <b>April 29, 1996</b>						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>219 West Bel Air Avenue, Aberdeen, Maryland</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature <i>John Anderson Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



96 14791

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES RICHARD SPIES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27, 1996</b>		3. TIME OF DEATH <b>11:05 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-42-0124</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 17, 1942</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Abingdon</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3309 Philadelphia Rd.</b>				10f. ZIP CODE <b>21009</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Heavy Equipment Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Paul Spies</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Day Hopkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Priscilla L. Spies</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 Philadelphia Rd., Abingdon, Md. 21009</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cokesbury U.M. Cemetery 5-1-96</b>		20c. LOCATION — City or Town, State <b>Abingdon, Md.</b>		22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>METASTATIC LIVER DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>16 MONTHS</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>COLON CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 YEARS</b>	
		c. <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>9 DAYS</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE, CACHEXIA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD.</i>				29c. LICENSE NUMBER <b>D 31856</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 28, 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DESH SHARMA MD 1814 BELAIR RD FALLSTON MD 21047</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 1 - 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14792

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William John Sherry, Jr.</b>						2. Date of Death Month <b>April</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>6:52 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>220-62-3266</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 20, 1953</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>420 Hiob Lane</b>				10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>			16b. Kind of Business/Industry <b>Machinist</b>			
17. Father's Name (First, Middle, Last) <b>William John Sherry, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Eileen Smith</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William J. Sherry, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Berch Ct., Port Deposit, Maryland 21903</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>5/3/96</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kirsten Amy Unglesbee</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Acute Coronary Thrombosis</b> Due to (or as a consequence of):										<b>1 mmed</b>
b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):										<b>2 yrs</b>
c. <b>Gen. Ant. Sclerotic CV Disease</b> Due to (or as a consequence of):										<b>5 yrs</b>
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Dudley R. Plushyn, MD</b>						29c. License number <b>D09482</b>		29d. Date signed (Month, Day, Year) <b>5/4/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
State Registrar		31. Date filed (Month, Day, Year) <b>MAY 3 - 1996</b>		32. Registrar's Signature <b>J. A. Anderson-Randall</b>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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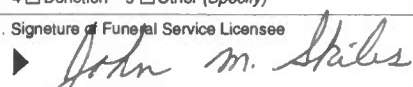

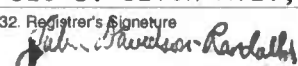
Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14793

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>SISTER MARY JOSEPH SMITH</b>						2. Date of Death Month Day Year <b>MAY 1, 1996</b>		3. Time of Death <b>12:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>VILLA ST. MICHAEL</b>						4b. City, Town, or Location of Death <b>EMMITSBURG</b>		4c. County of Death <b>FREDERICK</b>	
<b>Funeral Director</b>	5. Social Security Number <b>052-40-8446</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 16, 1913</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>FREDERICK</b>		10c. City, Town or Location <b>EMMITSBURG</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>333 S. SETON AVE.</b>				10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>U. S. A.</b>				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>			16b. Kind of Business/Industry <b>RELIGIOUS COMMUNITY DAUGHTERS OF CHARITY</b>			
17. Father's Name (First, Middle, Last) <b>JOSEPH S. SMITH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY GERTRUDE WALTER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SISTER CAMILLA HARANT</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>333 S. SETON AVE., EMMITSBURG, MD. 21727</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. JOSEPH'S</b>			Date <b>5/3/1996</b>		20c. Location - City or Town, State <b>EMMITSBURG, MD. 21727</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727</b>				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Cerebrovascular Accident</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>Atherosclerotic Cerebrovascular disease</b></p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>3 weeks</b></p> <p><b>10 years</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>(R) Frontal Meningioma with Seizure Disorder</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number <b>518705</b>		29d. Date signed (Month, Day, Year) <b>MAY 1, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727</b>										
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

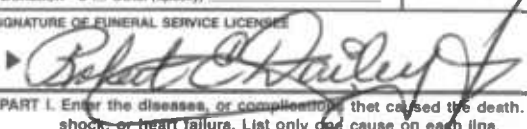
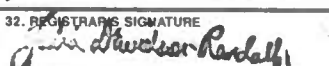




96 14794

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL Elmer SPALDING</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>30</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>11:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-20-8331</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 26, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>16 Frederick Avenue</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>7</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Creager Coal Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles W. Spalding</b>				18. MOTHER'S NAME (First, Middle, Surname) <b>Bertha Elizabeth Phillips</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald L. Spalding</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13703 Strafford Lane, Thurmont, MD 21788</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Weller Cemetery</b>		20c. DATE <b>5/4</b>		20d. LOCATION — City or Town, State <b>Thurmont, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarct? pulmonary Emboli?</b> DUE TO (OR AS A CONSEQUENCE OF)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Fracture Interthoracic (L) Hip 4/23/96 preceding on admission</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Pulmonary embolism infarct on 4/30/96 Repair Fracture</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Long History COPD. Coronary artery Disease Hx MI</b> <b>CHE 700</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>04/23/96</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>FELL</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>MERIDIAN NURSING CENTER</b>			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>400N. AVE FREDERICK MD 21701</b>					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>Robert R. Kotens MD D09861 5/12/96</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shao-Huang Chiu, M.D.</b>				29c. LICENSE NUMBER <b>D15681</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/30/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Shao-Huang Chiu, MD 187 Thomas Johnson Drive, Frederick, MD 21702</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LeRoy Cleveland Summers				2. DATE OF DEATH MONTH DAY YEAR April 29, 1996		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 213-16-1808		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 19, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13035 Brice Road				10f. ZIP CODE 21788		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Cleveland L. Summers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora S.E. Baugher			
19a. INFORMANT'S NAME (Type/Print) Mary E. Summers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13035 Brice Road, Thurmont, Maryland 21788			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 5/3		20c. LOCATION — City or Town, State Frederick, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Dailey</i>	
22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Bilateral pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>aspiration</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Emphysema</i> DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>alzheimer's</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lloyd E. Halvorson</i>				29c. LICENSE NUMBER D22101		29d. DATE SIGNED (Month, Day, Year) 5/3/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lloyd E. Halvorson, MD 1475 Taney Avenue, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) MAY 03 1996				32. REGISTRAR'S SIGNATURE <i>John A. Halvorson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

14796

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Cornelius Slagle

2. Date of Death

Month Day Year  
April 25, 1996

3. Time of Death

9:38 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-07-0607

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 20, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Brooklawn Apartments #319  
1001 Carroll Parkway

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

U.S. Government Employee

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

George C. Slagle Sr.

18. Mother's Name (First, Middle, Maiden Sumame)

Margaret Gertrude Blumenauer

19a. Informant's Name/Relationship (Type, Print)

Geraldine M. Slagle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1001 Carroll Parkway Apt. #319 Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

4/29

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST. FREDERICK, MD 2170123a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Bronchopneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1-2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. exacerbated Bronchogenic CT  
Due to (or as a consequence of):

12 mo

c. lung  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D146 ZC

29d. Date signed (Month, Day, Year)

Apr 25, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D G Droussch 501 W Scutts St Frederick MD 21701

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

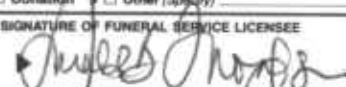
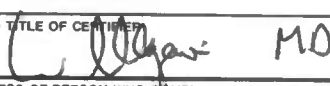
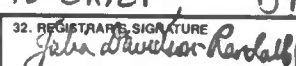
State  
Registrar



96 14797

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Grace Ruth Steplowski</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 20, 1996</b>		3. TIME OF DEATH <b>11:50 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>098-12-2040</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 5, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Vindabona Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Braddock Hgts.</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Lisbon</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>15904 Frederick Rd.</b>				10f. ZIP CODE <b>21765</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lee Kidd</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lula Bell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joetta R. Harris (Daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15904 Frederick Rd., Lisbon, Md. 21765</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematorium or other place) <b>Blue Ridge Memorial Gardens 4/24</b>		20c. LOCATION — City or Town, State <b>Prosperity, W. Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death <b>year</b>	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>016675</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WAYNE AUGMER, BRUNSWICK MD 21716</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14798

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAJOR THOMAS SELBY</b>		2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>6:55pm</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>212-12-3542</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>01/19/15</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Md.</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Pocomoke</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2212 Worcester Highway</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>W.W.I</b> If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer/Carpenter</b>		16b. Kind of Business/Industry <b>Own Business</b>
	17. Father's Name (First, Middle, Last) <b>William E.C. Selby</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie Pruitt Selby</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Selby- Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 2, Greenbackville, Va. 23356</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>1st Baptist Cemetery</b>		20c. Location - City or Town, State <b>5/8/96 Pocomoke, Md.</b>
	21. Signature of Funeral Service Licensee <b>Patricia L. Dennis</b>		22. Name and Address of Facility <b>Dennis Funeral Home--P.O. Box 87 Snow Hill, Md. 21863</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. chronic obstructive lung disease</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Intestinal Issues, Malnutrition</b> <b>Peritonitis, Arteriosclerosis</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>P37670</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. L. M. Evangelista</b> <b>105 Pine Bluff Rd #4 Salisbury, MD 21801</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 14799

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kenneth Edward Schmidlin</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>27</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>0230</b> M	
4. SOCIAL SECURITY NUMBER <b>220-80-7606</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>28</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-19-1968</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Route #13</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Princess Anne</b>	
9c. COUNTY OF DEATH <b>Somerset</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2709 N. Buck Harbor Ct.</b>	
10f. ZIP CODE <b>21851</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef &amp; Musician</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Francis J. Schmidlin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Geraldine Anderson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Geraldine Schmidlin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2709 N. Buck Harbor Ct., Pocomoke, Md 21851</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Pitts Creek Presbyterian Cem. 4/30 Pocomoke City, Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott S. Melson</b>				22. NAME AND ADDRESS OF FACILITY <b>Melson Funeral Home PO Box 64, Pocomoke City, Md. 21851</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SKULL FRACTURE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Md Grd Rd Rt 13</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James A. Sterling, MD</b>				29c. LICENSE NUMBER <b>D10214</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-2-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES A. STERLING, MD., 320 W. MAIN ST., CRISFIELD, MD. 21817</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 07 1996</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Herbert Edward Robinson  
3-19-1963  
Route # 13

1000  
1000

1000  
1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14800

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES STOREY</b>					2. Date of Death Month <b>May</b> Day <b>6th</b> Year <b>1996</b>		3. Time of Death <b>04:15 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>					4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>						
Funeral Director	5. Social Security Number <b>217-30-1404</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 23, 1933</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number <b>1900 MARYMONT ROAD</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>55-56</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CABLE FOREMAN</b>		16b. Kind of Business/Industry <b>TELEPHONE</b>							
	17. Father's Name (First, Middle, Last) <b>MATTHEW STOREY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>THELMA HARKEY</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>BARBARA S. STOREY</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1900 MARYMONT RD SILVER SPRING, MD 20906</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRETT MEMORIAL GARDENS</b>		Date <b>5/8/96</b>		20c. Location - City or Town, State <b>OAKLAND, MARYLAND</b>							
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MO0167</b>				22. Name and Address of Facility <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Hepatocellular Carcinoma</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>&gt; 3 months</b></td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Hepatocellular Carcinoma</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>&gt; 3 months</b>	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Hepatocellular Carcinoma</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>&gt; 3 months</b>												
	b. _____ Due to (or as a consequence of):													
	c. _____ Due to (or as a consequence of):													
	d. _____ Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) _____		28b. Time of Injury _____ M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred _____					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) _____		28f. Location (Street and Number or Rural Route Number, City or Town, State) _____									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>					29c. License number <b>D32417</b>		29d. Date signed (Month, Day, Year) <b>May 6th, 1996</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rahul Gilotra MD. 12016 GEORGIA AVE Wheaton MD 20902</b>														
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>			32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

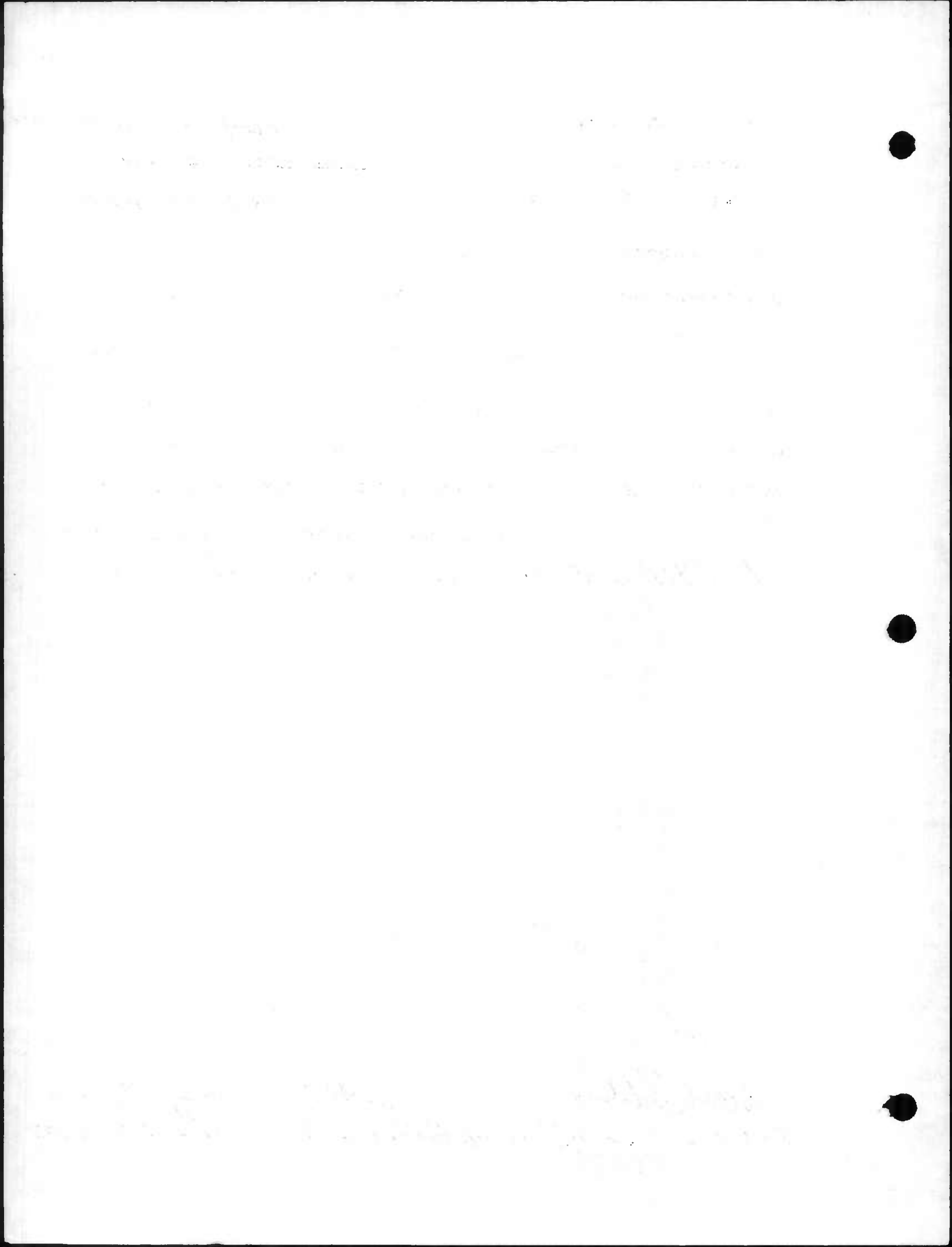
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


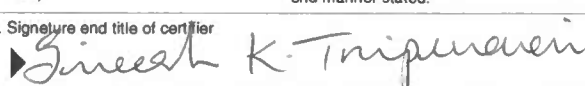
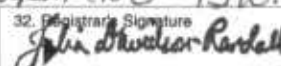
Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

14801

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARIE L. SNYDER</b>				2. Date of Death Month <b>May</b> Day <b>13<sup>th</sup></b> Year <b>96</b>		3. Time of Death <b>11:20 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>Baltimore City</b>			
<b>Funeral Director</b>	5. Social Security Number <b>170-24-1857</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-30-08</b>			
	9. Birthplace (State or Foreign Country) <b>Ontario, Canada</b>									
Usual Residence of Decedent										
10a. State <b>Maryland</b>			10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baldwin-Baltimore County</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>13910 Baldwin Mill Rd.</b>				10f. Zip Code <b>21013</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>			16b. Kind of Business/Industry <b>Retail Clothing Industry</b>				
17. Father's Name (First, Middle, Last) <b>Levi Lougheed</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Murray</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Roger R. Snyder</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13910 Baldwin Mill Rd. Baldwin, Md. 21013</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		Date <b>5-15-96</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </td> <td style="width:70%; vertical-align: top;"> <p>a. <b>cerebro vascular accident</b> Due to (or as a consequence of):</p> <p>b. <b>Atrial arrhythmias</b> Due to (or as a consequence of):</p> <p>c. <b>congestive heart failure</b> Due to (or as a consequence of):</p> <p>d. _____</p> </td> </tr> </table>									<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>	<p>a. <b>cerebro vascular accident</b> Due to (or as a consequence of):</p> <p>b. <b>Atrial arrhythmias</b> Due to (or as a consequence of):</p> <p>c. <b>congestive heart failure</b> Due to (or as a consequence of):</p> <p>d. _____</p>
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>	<p>a. <b>cerebro vascular accident</b> Due to (or as a consequence of):</p> <p>b. <b>Atrial arrhythmias</b> Due to (or as a consequence of):</p> <p>c. <b>congestive heart failure</b> Due to (or as a consequence of):</p> <p>d. _____</p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number <b>D 30661</b>		29d. Date signed (Month, Day, Year) <b>May 13<sup>th</sup> 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Suresh K. TRIPATHI - 13111 Ring Factory Rd - Belair, md 21014</b>										
31. Date filed (Month, Day, Year) <b>MAY 17 1996</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





96 14802

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth JaVis Squares</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>4</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>9:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-24-0108</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/21/12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Berlin</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10498 Worcester Hwy.</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Kendall Jarvis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hester Catherine Clark</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Roy Squares</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10498 Worcester Hwy. Berlin, MD 21811</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Cemetery 5/5/96</b>		20c. LOCATION — City or Town, State <b>Berlin, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Burbage Funeral Home 108 Williams St. Berlin, MD 21811</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Alzheimer's Disease - Advanced stage</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate interval Between Onset and Death <b>Several years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Dehydration, Decubitus ulcer left hip - Stage II</b> <b>ASCVD with history of Atrial Fibrillation. Diabetes Mellitus</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Shrestha M.D.</b>				29c. LICENSE NUMBER <b>D 16278</b>		29d. DATE SIGNED (Month, Day, Year) <b>5.4.96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. M. Shrestha: P.O. BOX 2018 : Salisbury, Md. 21802</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 06 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14803

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fannie Mae TESTER

2. Date of Death

May 3, 1996

3. Time of Death

1:50AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE

5. Social Security Number

211-03-1266

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 11, 1919

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGE

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2117 CHARLESTON PLACE

10f. Zip Code

20783

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME MAKING

17. Father's Name (First, Middle, Last)

EUGENE T. HEITTER

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH C. SCHUURE

19a. Informant's Name/Relationship (Type, Print)

JOHN W.D. TESTER, III -Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1263 PINE HILL DR., ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLL CREMATION

Date

5/4/96

20c. Location - City or Town, State

HAMPSTEAD, MD. 21074

21. Signature of Funeral Service Licensee

R. L. Lister

22. Name and Address of Facility

FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days  
many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. Devore MD

29c. License number

D01852

29d. Date signed (Month, Day, Year)

May 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



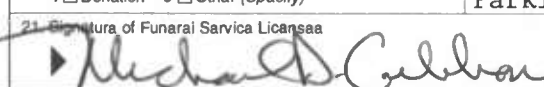

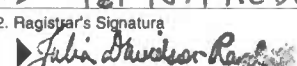
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14804

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Elizabeth Teunis</b>				2. Date of Death Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b>				3. Time of Death <b>12:05AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577-28-2111</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 5, 1909</b>		9. Birthplace (State or Foreign Country) <b>Michigan</b>	
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. Street and Number <b>18750 Cross Country Lane</b>				10f. Zip Code <b>20879</b>				10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk/Secretary</b>				16b. Kind of Business/Industry <b>Federal Government</b>	
	17. Father's Name (First, Middle, Last) <b>Roelf Teunis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Bouwman</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Marcia J. Miller</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18750 Cross Country Lane, Gaithersburg, MD. 20879</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		Data <b>5/3/96</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr., Gaithersburg, MD. 20877</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Complete Heart Block</b> Dua to (or as a consequence of): <b>b. Acute myocardial infarction</b> Dua to (or as a consequence of): <b>c. Acute respiratory failure</b> Dua to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>10 Hours</b> <b>Days</b> <b>Hours</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>1D41866</b>		29d. Date signed (Month, Day, Year) <b>APRIL 28, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KANAN HUDHUD, MD 481 N. FREDERICK AVE, 230 GAITHERSBURG, MD</b>		31. Date filed (Month, Day, Year) <b>MAY 02 1996</b>		32. Registrar's Signature 						
State Registrar										

*[Faint, illegible handwritten notes]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14805

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES Walker THOMAS, Sr.</b>		2. Date of Death Month Day Year <b>April 23 1996</b>		3. Time of Death <b>8:25 Pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>
Funeral Director	5. Social Security Number <b>579-52-5975</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 11, 1912</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		
Usual Residence of Decedent					
10a. State <b>D.C.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Washington</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>4432 Douglas Street N.E.</b>		10f. Zip Code <b>20019</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Ret. 1972</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Educator</b>		16b. Kind of Business/Industry <b>University</b>	
17. Father's Name (First, Middle, Last) <b>Spencer Thomas</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Molly Stewart</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charles W. Thomas, Jr., son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16745 Sunderland Rd., Detroit, Michigan 48219</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cem.</b>		20c. Location - City or Town, State <b>5/2/96 Ft. Myer, Virginia</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration, Pneumonia, acute</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Approximate Interval Between Onset and Death <b>hours</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Generalized atherosclerotic cardiovascular disease</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>April 23, 1996</b>		28b. Time of Injury <b>UNIC M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Vomited, aspirated</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>9211 Stuart Ln. Clinton, Md 20735</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Allegis of Southern Md, Nursing Home</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number <b>D25925</b>	
29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. BERGER #205, 7720 WISCONSIN AVE Bethesda, Md 20814</b>					
31. Date filed (Month, Day, Year) <b>MAY 02 1996</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

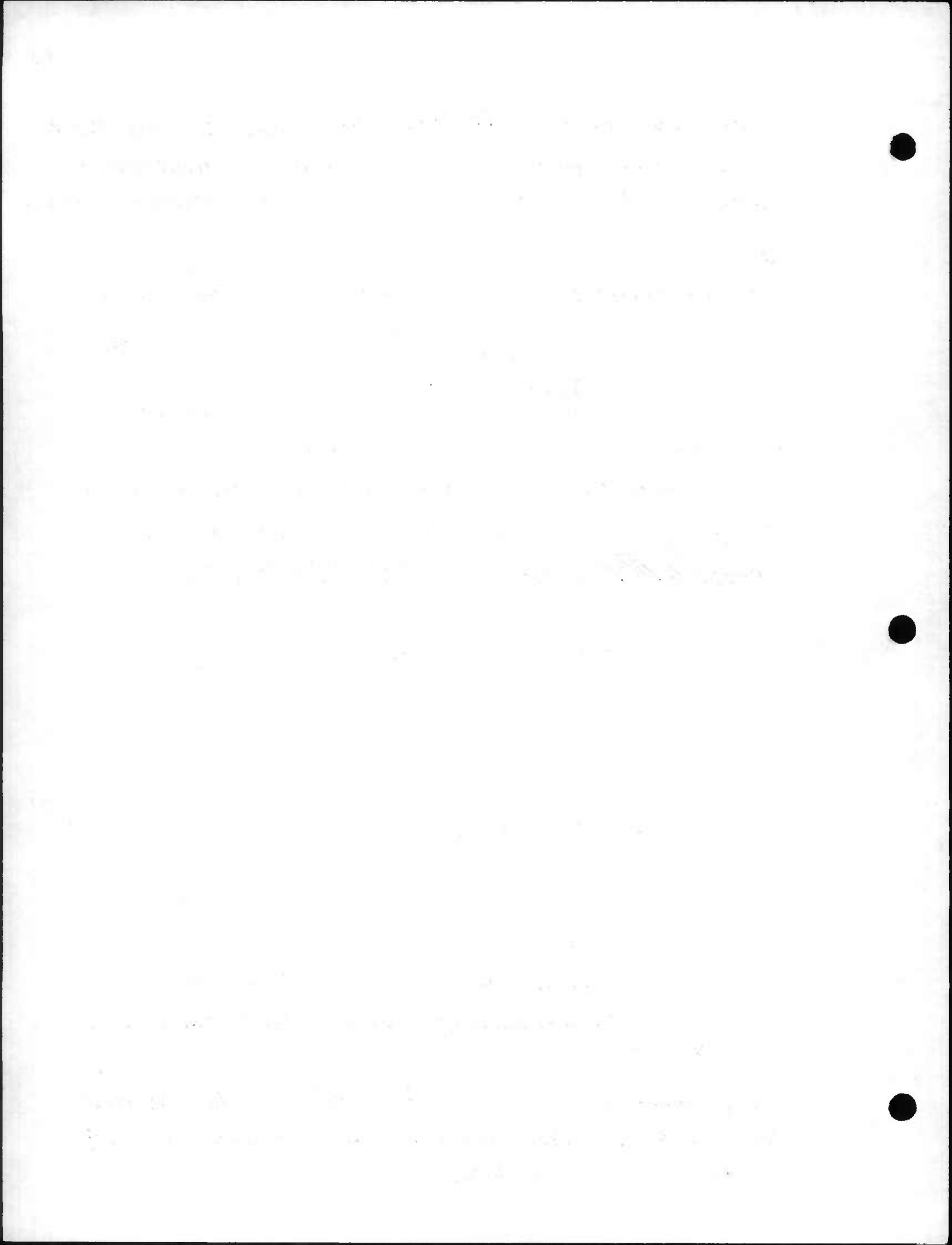
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14806

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLADYS L. THOMAS</b>				2. Date of Death Month <b>APRIL</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>8:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>579-05-3012</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 24, 1912</b>	9. Birthplace (State or Foreign Country) <b>WASH. D.C.</b>
	Usual Residence of Decedent							
10a. State <b>D.C.</b>		10b. County <b>NONE</b>		10c. City, Town or Location <b>WASHINGTON</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3298 FT. LINCOLN DR. N.E. #325</b>				10f. Zip Code <b>20018</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STATISTICAL ASST. TYPING</b>		16b. Kind of Business/Industry <b>FED. GOV'T.</b>		
17. Father's Name (First, Middle, Last) <b>HENRY THOMAS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LUCY GREEN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>REUBEN T. HARRIS/ COUSIN</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15207 TOTTENHAM TERR., SILVER SPRING, MD. 20906-1425</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>4/29</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>		
21. Signature of Funeral Service Licensee <b>W.W. Chambers</b> MO0091				22. Name and Address of Facility <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary Heart Failure</b> Due to (or as a consequence of): b. <b>Severe Coronary Artery Disease and Aortic Stenosis</b> Due to (or as a consequence of): c. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 hrs.</b> <b>1-2 years</b> <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Pradeep Srivastava MD</b>				29c. License number <b>033493</b>		29d. Date signed (Month, Day, Year) <b>4/26/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>PRADEEP SRIVASTAVA MD, 7227-B Hanover Parkway, Greenbelt MD 20770</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>		32. Registrar's Signature <b>Julia Davidson</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

REPORT OF THE BOARD

APRIL 1, 1900

TO THE STOCKHOLDERS OF THE  
SOUTHERN PACIFIC RAILROAD COMPANY

FOR THE YEAR ENDING  
MARCH 31, 1900

AND FOR THE YEAR ENDING  
MARCH 31, 1901

AND FOR THE YEAR ENDING  
MARCH 31, 1902

AND FOR THE YEAR ENDING  
MARCH 31, 1903

AND FOR THE YEAR ENDING  
MARCH 31, 1904

AND FOR THE YEAR ENDING  
MARCH 31, 1905

AND FOR THE YEAR ENDING  
MARCH 31, 1906

AND FOR THE YEAR ENDING  
MARCH 31, 1907

AND FOR THE YEAR ENDING  
MARCH 31, 1908

AND FOR THE YEAR ENDING  
MARCH 31, 1909

AND FOR THE YEAR ENDING  
MARCH 31, 1910

AND FOR THE YEAR ENDING  
MARCH 31, 1911

AND FOR THE YEAR ENDING  
MARCH 31, 1912

AND FOR THE YEAR ENDING  
MARCH 31, 1913

AND FOR THE YEAR ENDING  
MARCH 31, 1914

AND FOR THE YEAR ENDING  
MARCH 31, 1915

AND FOR THE YEAR ENDING  
MARCH 31, 1916

AND FOR THE YEAR ENDING  
MARCH 31, 1917

AND FOR THE YEAR ENDING  
MARCH 31, 1918

AND FOR THE YEAR ENDING  
MARCH 31, 1919

AND FOR THE YEAR ENDING  
MARCH 31, 1920

AND FOR THE YEAR ENDING  
MARCH 31, 1921

AND FOR THE YEAR ENDING  
MARCH 31, 1922

AND FOR THE YEAR ENDING  
MARCH 31, 1923

96 14807

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LIBBY TOPCHIK</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>23</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>8:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>143-12-4746</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 25, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Poland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Hebrew Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>9910 Fernwood Road</b>	
10f. ZIP CODE <b>Bethesda</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>David Prozansky</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leah (unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Topchik</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9910 Fernwood Road Bethesda MD 20817</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Riverside Cemetery</b>		20c. LOCATION — City or Town, State <b>4/26 Rochelle Park, NJ</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Edward Sagel Fuernal Direction</b> <b>1001 Rockville Pike Rockville MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CANCER OF UMBILICUS</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>P. Talwar, M.D.</b>				29c. LICENSE NUMBER <b>D 36552</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 23 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>P. TALWAR, 6121 MONTROSE ROAD, ROCKVILLE MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 30 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14808

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Clair Treese</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>24</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>187-01-2715</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>February 2, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing &amp; Rehabilitation Ctr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>Howard</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Beltsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>13123 Greenmount Avenue</b>				10f. ZIP CODE <b>20705</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Railroad Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Murray Treese</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Olive Burkett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Greg A. Treese</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakemont Memorial Gardens April 29, 1996</b>		20c. LOCATION — City or Town, State <b>Davidsonville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death <b>3 Days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Flowers MD</i>				29c. LICENSE NUMBER <b>D20789</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 25, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Flowers MD 11055 Little Patuxent Pkwy., #104 Columbia, Maryland 21044</b>							
31. DATE FILED (Month, Day, Year) <b>APR 30 1996</b>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RESEARCH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14809

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Tereszczuk</b>				2. Date of Death Month Day Year <b>April 30 1996</b>		3. Time of Death <b>2250</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>222-03-4998</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 28 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Chesapeake City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>179 Basil Ave</b>		10f. Zip Code <b>21915</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1938</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Iron Worker</b>		16b. Kind of Business/Industry <b>Construction</b>				
17. Father's Name (First, Middle, Last) <b>John Tereszczuk</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Macreski</b>		19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth Alcorn</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>179 Basil Ave., Chesapeake City MD 21915</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St Rose of Lima May 4 1996</b>		20c. Location - City or Town, State <b>Chesapeake City MD</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>R. T. Foard Funeral Home, P.A. 318 George St., Chesapeake City MD 21915</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Atherosclerotic Heart Disease</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>years</b>		
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>023322</b>		29d. Date signed (Month, Day, Year) <b>5/1/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sheelmohan Sachdev M.D. 118 North St Ste 3B. Elkton, MD 21921</b>		31. Data filed (Month, Day, Year) <b>MAY 02 1996</b>		32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

3+1VA

State  
Registrar





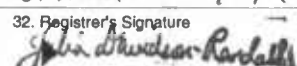
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14810

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patsy Ruth Toms</b>				2. Date of Death Month <b>May</b> 1, <b>1996</b> Day Year		3. Time of Death <b>8:45 P. M.</b>						
	4e. Facility Name (If not institution, give street and number) <b>8082 Geaslin Drive</b>				4b. City, Town, or Location of Death <b>Middletown</b>		4c. County of Death <b>Frederick</b>						
Funeral Director	5. Social Security Number <b>215-20-8337</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 11, 1927</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>					
	Usual Residence of Decedent												
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Middletown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>8082 Geaslin Drive</b>				10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>U. S. A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>		16b. Kind of Business/Industry <b>own home</b>							
17. Father's Name (First, Middle, Last) <b>George F. Grove</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marguerite Carter Appleby</b>									
19e. Informant's Name/Relationship (Type, Print) <b>Eric M. Toms</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8082 Geaslin Drive Middletown, Maryland 21769</b>									
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>5/6/96</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald B. Thompson Funeral Home 31 E. Main Street Middletown, Maryland 21769</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.													
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Metastatic Breast Cancer</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>6 months</b></td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Metastatic Breast Cancer</b>	Approximate Interval Between Onset and Death <b>6 months</b>	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Metastatic Breast Cancer</b>	Approximate Interval Between Onset and Death <b>6 months</b>											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>Michael J. McCormack M.D.</b>				29c. License number <b>041667</b>		29d. Date signed (Month, Day, Year) <b>5-6-96</b>							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael J. McCormack 1799 Howell Rd. Hagerstown, MD 21740</b>													
31. Date filed (Month, Day, Year) <b>MAY 08 1996</b>		32. Registrar's Signature 											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14811

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Gilman

Tighe

2. Date of Death

April 30 1996

Day

Year

3. Time of Death

11:00 p.m.

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

031-30-3167

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec 25 1906

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

928 Beacon Square Court

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates 1942/47

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Civil engineer

16b. Kind of Business/Industry

MA Government

17. Father's Name (First, Middle, Last)

Joseph Tighe

18. Mother's Name (First, Middle, Maiden Surname)

Henietta Gilman

19a. Informant's Name/Relationship (Type, Print)

Charlotte Tighe wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

928 Beacon Square Ct. Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Monocacy

Date

5/4/96

20c. Location - City or Town, State

Beallsville, MD

21. Signature of Funeral Service Licensee

Wm C. Kitt

22. Name and Address of Facility

Hilton Funeral Home

Barnesville, MD 20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. polymicrobial pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic myelocytic leukemia

Due to (or as a consequence of):

10 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D43083

29d. Date signed (Month, Day, Year)

April 30, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George A. Sotos 9797 Medical Center Dr. Rockville, MD

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's signature

Charles R. Rabbitt

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14812

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>LEO BERNARD TOPPER, SR.</b>					2. Date of Death Month Day Year <b>APRIL 23, 1996</b>		3. Time of Death <b>1:30 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>28 FEDERAL AVE.,</b>					4b. City, Town, or Location of Death <b>EMMITSBURG</b>		4c. County of Death <b>FREDERICK</b>		
<b>Funeral Director</b>	5. Social Security Number <b>215-12-1201</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 26, 1919</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>			10b. County <b>FREDERICK</b>			10c. City, Town or Location <b>EMMITSBURG</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>28 FEDERAL AVE.</b>					10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>U. S. A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MASON</b>			16b. Kind of Business/Industry <b>CONSTRUCTION</b>		
17. Father's Name (First, Middle, Last) <b>JAMES RAY TOPPER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>STELLA A. WOLFE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>PHILIP TOPPER</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PHILIP TOPPER, 32 FEDERAL AVE., EMMITSBURG, MD. 21727</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SMITHSBURG CREMATORIUM</b>			Data <b>4/24/96</b>		20c. Location - City or Town, State <b>SMITHSBURG, MD.</b>		
21. Signature of Funeral Service Licensee <i>John M. Skiles</i>					22. Name and Address of Facility <b>SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Coronary Heart Failure</i></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><i>3 years</i></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14813

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Walter Fred Taylor Sr.</b>		2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>0837</b>	
4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
5. Social Security Number <b>225-18-3953</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1-14-22</b>
9. Birthplace (State or Foreign Country) <b>Virginia</b>		Usual Residence of Decedent			
10a. State <b>VA</b>	10b. County <b>Accomack</b>	10c. City, Town or Location <b>Temperanceville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>10291 Lankford Hwy.</b>		10f. Zip Code <b>23442</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>(John W. Taylor owner-packing co.)</b>	
16b. Kind of Business/Industry <b>Food Processing</b>		17. Father's Name (First, Middle, Last) <b>Nathaniel F. Taylor</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Corbin</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Thelma E. Taylor</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10291 Lankford Hwy., PO Box Temperanceville, VA</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>John W. Taylor Cemeter 5-8-96</b>		20c. Location - City or Town, State <b>Temperanceville VA</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fox Funeral Home, PO Box 278, Temperanceville, VA 23442</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):  b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D34768</b>		29d. Date signed (Month, Day, Year) <b>5/6/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HELAND, M.D. 500 RIVERSIDE DR. B101 SALISBURY, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>MAY 07 1996</b>		32. Registrar's Signature 			

State  
Registrar





96-2147-021  
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14814

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DAVID M. TETLOW</b>					2. Date of Death Month Day Year <b>APRIL 20, 1996</b>		3. Time of Death <b>0215 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>ROUTE#85 SOUTH OF I-270</b>					4b. City, Town, or Location of Death <b>FREDERICK CITY</b>		4c. County of Death <b>FREDERICK</b>		
<b>Funeral Director</b>	5. Social Security Number <b>220-70-9828</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 3, 1958</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>			10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2739 Thurston Road</b>					10f. Zip Code <b>21704</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Real Estate Agent</b>			16b. Kind of Business/Industry <b>Real Estate</b>				
17. Father's Name (First, Middle, Last) <b>Arthur Roland Tetlow</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy Nester</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Nancy Nester Tetlow-Webb</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2739 Thurston Rd., Frederick, Maryland 21704</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory April 24, 1996 Smithsburg, Maryland</b>			Date <b>April 24, 1996</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Richard C.C. Basford</i> M00021					22. Name and Address of Facility <b>Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Multiple Injuries</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>4-20-96</b>		28b. Time of Injury <b>0230 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Driver - single vehicle accident</b>	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>I 270</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>APRIL 20, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>APR 24 1996</b>			32. Registrar's Signature <i>[Signature]</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner



96 14815

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>FLORENCE FAYE TAYLOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR. 26, 1996</b>		3. TIME OF DEATH <b>21:53</b> M	
4. SOCIAL SECURITY NUMBER <b>577-50-9622</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01/30/1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Garrett Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>WV</b>		10b. COUNTY <b>Preston</b>		10c. CITY, TOWN OR LOCATION <b>Terra Alta</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>202 W. Washington ave.</b>				10f. ZIP CODE <b>26764</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>02</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Health care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frederich W. Lange</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence T. Kingsbury</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John A. Taylor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>202 W. Washington ave., Terra Alta, WV.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Aurora Cemetery 4/29/96</b>		20c. LOCATION — City or Town, State <b>Aurora, WV.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark C. Spear</i>				22. NAME AND ADDRESS OF FACILITY <b>Arthur H. Wright Funeral Home, Inc. 105 Highland ave., Terra Alta, WV.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Multiple Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i>Atherosclerotic Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <i>Diabetes Mellitus</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Roger A. Lewis</i>				29c. LICENSE NUMBER <b>D26568</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-7-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Roger A. Lewis, M.D., 603B State Avenue, Terra Alta, WV 26764</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14816

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>John W. Utecht</b>					2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>1996</b>			3. Time of Death <b>11:54am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>					4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>325-07-4926</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3-21-1918</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>8505 Meadowlark Lane</b>					10f. Zip Code <b>20817</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII &amp; Korea</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>+4</b> College (1-4 or 5+) <b>+4</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronic Engineer</b>			16b. Kind of Business/Industry <b>Engineering</b>		
17. Father's Name (First, Middle, Last) <b>John F. Utecht</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Emilie Greenberg</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gwendolyn Utecht - Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8505 Meadowlark Lane, Bethesda, MD 20817</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Quantico National Ceme.</b>			Date <b>4/29/96</b>		20c. Location - City or Town, State <b>Quantico, Virginia</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Myocardial infarction</b> Due to (or as a consequence of):</p> <p>b. <b>Hypertension</b> Due to (or as a consequence of):</p> <p>c. <b>Atherosclerotic vascular disease</b> Due to (or as a consequence of):</p> <p>d. <b>TIA's</b></p> </div> </div>										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asthma, benign prostatic hypertrophy</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  <b>Susan Baruch M.D.</b>					29c. License number <b>D39563</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Susan G. Baruch, M.D., 10215 Fernwood Road, #100, Bethesda, Maryland 20817</b>										
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12



96 14817

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William George Vassos				2. DATE OF DEATH MONTH DAY YEAR April 24 1996		3. TIME OF DEATH 11:50 A M	
4. SOCIAL SECURITY NUMBER 579-18-2686		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1921	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3905 Ilford Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Veterans Administration			
17. FATHER'S NAME (First, Middle, Last) George William Vassilopoulos				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Valco			
19a. INFORMANT'S NAME (Type/Print) Sotiria P. Vassos				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Ilford Road, Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/29/96 Silver Spring, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>END STAGE CONGESTIVE CARDIOMIOPATHY</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CORONARY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval Between Onset and Death 3 years 20+ years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>R. A. Mathews, MD</u>				29c. LICENSE NUMBER <u>D18924</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-24-96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>RAFAEL A. MATHEUS, MD 13018 GEORGIA AVE. WHEATON, MD 20906</u>							
31. DATE FILED (Month, Day, Year) <u>APR 26 1996</u>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14818

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Julia Jean Van Dyk</b>				2. Date of Death Month Day Year <b>April 24, 1996</b>		3. Time of Death <b>2:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>7500 Masters Drive</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>509-30-2502</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 20, 1933</b>		9. Birthplace (State or Foreign Country) <b>Mexico</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7500 Masters Drive</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Art Teacher</b>			16b. Kind of Business/Industry <b>Primary Day School</b>	
17. Father's Name (First, Middle, Last) <b>Nicholas Covacevich</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Sue Jean Hill</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Frederick T. Van Dyk - Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7500 Masters Drive Potomac, MD 20854</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>			20c. Location - City or Town, State <b>4/28/96 Rockville, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>pancytopenia</u> Due to (or as a consequence of):  b. <u>bone metastases</u> Due to (or as a consequence of):  c. <u>multiple myeloma</u> Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  1 year  5 year  5 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how Injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>D35996</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda M. Burrell, M.D., 2101 Medical Park Drive, #201, Silver Spring, MD 20902</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

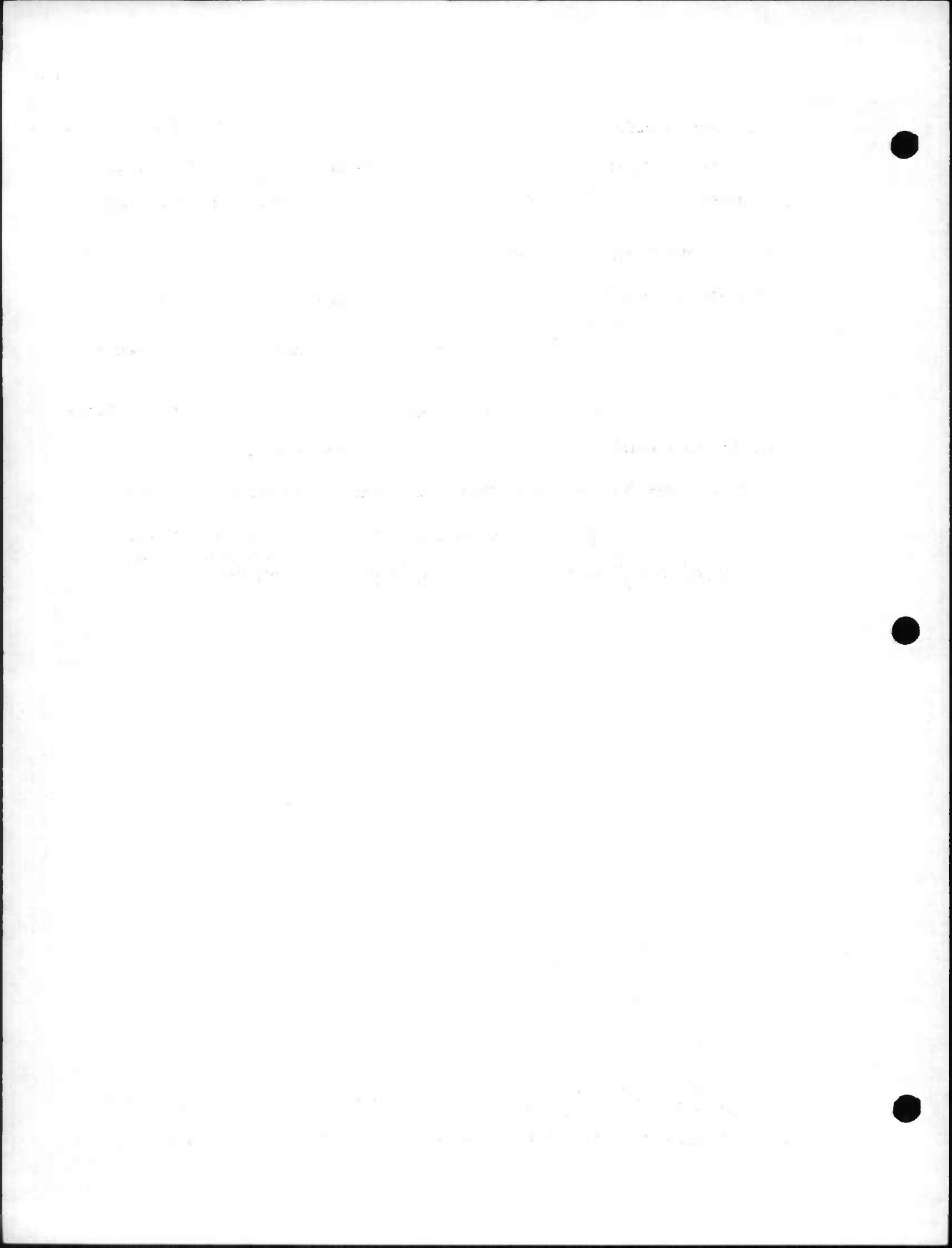
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



96 14819

ITEMS: 27, 28a-f, PER MED FILM G-739 9/9/96 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTHER ELSIE VESSEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> , YEAR <b>1996</b>		3. TIME OF DEATH <b>5:50 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-74-1595</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01/10/1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>8956 CRISFIELD HWY.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>WESTOVER</b>		9c. COUNTY OF DEATH <b>SOMERSET</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>SOMERSET</b>		10c. CITY, TOWN OR LOCATION <b>PRINCESS ANNE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>30594 PINE KNOLL DRIVE</b>				10f. ZIP CODE <b>21853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN LEWIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SURILDA PIERCE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY RANTZ</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30594 PINE KNOLL DRIVE, PRINCESS ANNE, MD. 21853</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>REHOBETH BAPTIST CEMETERY 5/2</b>		20c. LOCATION — City or Town, State <b>REHOBETH, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Hines</i> MO0295				22. NAME AND ADDRESS OF FACILITY <b>HINMAN FUNERAL HOME 21853 11673 SOMERSET AVE., PRINCESS ANNE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>hip fracture</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FEB. 22, 1996</b>		28b. TIME OF INJURY <b>3 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT COLLAPSED</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>SAME AS # 10</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mary L. Hines</i>					
		29c. LICENSE NUMBER <b>D24871</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/1/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>860 Riverside Drive 204A, Salisbury MD 21858</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1996</b>		32. REGISTRAR'S SIGNATURE <i>John H. Hines</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



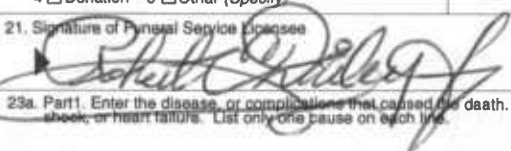
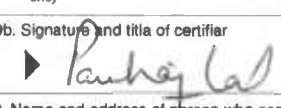
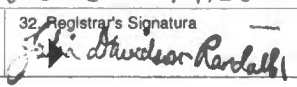
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14820

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>DOROTHY VIRGINIA KIRN VAN DEUSEN</b>				2. Date of Death Month <b>APRIL</b> Day <b>20</b> Year <b>1996</b>				3. Time of Death <b>11:40p.m</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-30-8387</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-10-1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>403 Buffalo Road</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+)			18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>None</b>			
	17. Father's Name (First, Middle, Last) <b>Grover Cleveland Kirn</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Winter</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Donald Van Deusen (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9528 Watkins Road Laytonsville, Md. 20882</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>			Data <b>2/21/96</b>		20c. Location - City or Town, State <b>Smithsburg, Washington Co.</b>	
	21. Signature of Funeral Service Director 				22. Name and Address of Facility <b>Robert E. Dailey &amp; Son Funeral Homes, p.A. 1201 N. Market St. Frederick, Md. 21701</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Artery Disease</b> Due to (or as a consequence of):</p> <p><b>b. Senile Dementia</b> Due to (or as a consequence of):</p> <p><b>c. Metastatic Cancer breast</b> Due to (or as a consequence of):</p> <p><b>d.</b></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death <b>3 yrs</b> <b>15 yrs</b> <b>10 yrs</b></p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal		28a. Date of Injury (Month, Day, Year) <b>APRIL 20, 1996</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier  M.D.				29c. License number <b>D 39671</b>		29d. Date signed (Month, Day, Year) <b>APRIL 21, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>11119 ROCKVILLE PIKE, SUITE 100 ROCKVILLE, MD 20852</b>									
31. Date filed (Month, Day, Year) <b>APR 20 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text in Devanagari script, appearing to be a letter or document. The text is faint and mostly illegible due to fading and bleed-through from the reverse side. Some fragments of text are visible, such as "प्रति" (Prati) and "आप" (Aap), which are common words in Hindi/Devanagari.

96 14821

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John Joseph Western</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>1</i> YEAR <i>96</i>		3. TIME OF DEATH <i>7:15P</i> M	
4. SOCIAL SECURITY NUMBER <i>216-60-2459</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 24, 1924</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Illinois</i>				9a. FACILITY NAME (If not institution, give street and number) <i>3502 Farthing Drive</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Wheaton</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Wheaton</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>3502 Farthing Drive</i>	
10f. ZIP CODE <i>20906</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1943-1945</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i>		17. KIND OF BUSINESS/INDUSTRY <i>Postal Service</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Morris Western</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Josephine Croghan</i>			
19. INFORMANT'S NAME (Type/Print) <i>Myrtle J. Western</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3502 Farthing Drive, Wheaton, Maryland 20906</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington National Cemetery</i>		20c. LOCATION — City or Town, State <i>Arlington, Virginia</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 20901 500 University Blvd.W. Silver Spring, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. acute myocardial infarction</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28. DATE OF INJURY (Month, Day, Year) <i></i>			
28a. DATE OF INJURY (Month, Day, Year) <i></i>				28b. TIME OF INJURY <i>M</i>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <i></i>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i></i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i></i>			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tamber</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>May-1-96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Tamber 8218 Wisconsin Ave Bethesda</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 03 1996</i>				32. REGISTRAR'S SIGNATURE <i>John Tamber</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2a is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14822

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William A. Wright</b>				2. Date of Death Month <b>April</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>2:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>356-03-8441</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 6, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>MINNESOTA</b>		10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>MITCHELLVILLE</b>	
Usual Residence of Decedent								
10e. Street and Number <b>10450 LOTTSFORD RD.</b>			10f. Zip Code <b>20721</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CRYPTOLOGIST</b>		
17. Father's Name (First, Middle, Last) <b>AMBROSE WRIGHT</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CULLY</b>			19. Informant's Name/Relationship (Type, Print) <b>ELIZABETH INGLIS/ NIECE</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 3057, KENNEBUNKPORT, ME. 04046</b>			20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		
20c. Location - City or Town, State <b>4/29 RIVERDALE, MD.</b>			21. Signature of Funeral Service Licensee <b>W.W. Chambers</b> M00091			22. Name and Address of Facility <b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>bilateral pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>2 days</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Congestive Heart Failure</b> <b>- Atherosclerotic Cardiovascular Disease</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) <b>4/27/96</b>								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Sam Tellawi</b>								
29c. License number <b>D34274</b>								
29d. Date signed (Month, Day, Year) <b>4.27.96.</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. SAM TELLAWI M.D. 7700 OLD BRANCH AVE., CLINTON, MD.</b>								
31. Date filed (Month, Day, Year) <b>APR 29 1996</b>								
32. Registrar's Signature <b>Juli Anderson-Ross</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Report of the  
Committee on  
the Administration of the  
Department of the Interior

For the  
Year 1904

Presented to the  
Senate and House of  
Representatives  
at their joint session  
on January 12, 1905

Washington:  
Government Printing Office  
1905

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14823

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Hazel R. Williams

2. Date of Death

Month Day Year  
April 26 1996

3. Time of Death

9:25 a.m.

4a. Facility Name (If not institution, give street and number)

MedPointe Nursing Home

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

218-52-4471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 23, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3634 Aldino Road

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self employed

16b. Kind of Business/Industry

Grocer

17. Father's Name (First, Middle, Last)

B.G.S. Jourdan

18. Mother's Name (First, Middle, Maiden Surname)

Janey Pyle

19a. Informant's Name/Relationship (Type, Print)

Sandra K. Holmes (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

337 S. Ann St., Baltimore, Maryland 21231

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris &amp; Co., Inc.

Date

4/27/96

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Kirsten Amy Eaglesbee

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. coronary artery disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. J. [Signature]

29c. License number

D28339

29d. Date signed (Month, Day, Year)

April 26, 1996

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

101 E. Wheel Road Bel Air, MD 21015

31. Date filed (Month, Day, Year)

APR 28 1996

32. Registrar's Signature

John [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14824

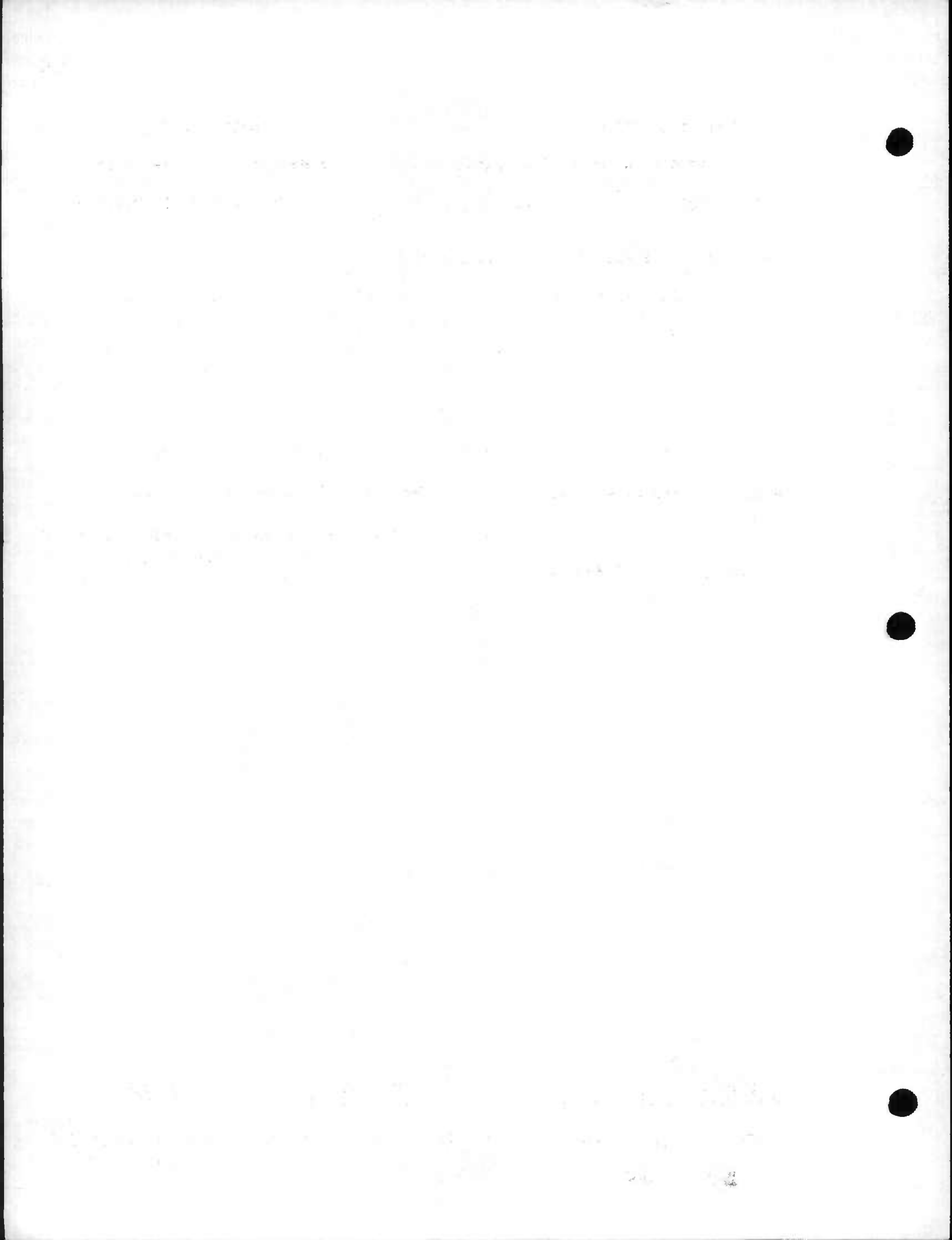
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN COLEMAN WILES</b>				2. Date of Death Month <b>April</b> , Day <b>28</b> , Year <b>1996</b>				3. Time of Death <b>8:00 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-10-5407</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 23, 1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>8333 Walter Martz Rd.</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>-</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Labor</b>		16b. Kind of Business/Industry <b>Factory</b>			
	17. Father's Name (First, Middle, Last) <b>Alvie Wiles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ilene Shankle</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Annie M. Smith Wiles / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5860 Genesis La. / Frederick, Md. 21703</b>					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		Date <b>4-30-96</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>1621 Opossumtown Pike / Frederick, Md. 21702</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonic</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>3 days</b>					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End Stage Renal Disease</b> <b>Parkinsonism</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William H. Johnson MD</i>		29c. License number <b>D47556</b>		29d. Date signed (Month, Day, Year) <b>4/28/96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William H. Johnson MD, 56 THOMAS JOHNSON DR, FREDERICK, MD 21702</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 01 1996</b>				32. Registrar's Signature <i>John Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Amended line 450,  
FCHD

96 14825

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carrie Margaret Zecher</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 20, 1996</b>		3. TIME OF DEATH <b>8:45 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-96-1730</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 30, 1908 Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Thompson's Home Care</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Keedysville</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Burkittsville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>104 W. Main St.</b>				10f. ZIP CODE <b>21718</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Boyer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Salome L. Blessing</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Margaret Brandenburg (Daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6319 Mt. Church Rd., Middletown, Md. 21769</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Union Cemetery</b>		DATE <b>4/23</b>		20c. LOCATION — City or Town, State <b>Burkittsville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastrointestinal bleed.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>peptic ulcer disease</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 wk.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Group Home</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>L. Meyer MD</b>		29c. LICENSE NUMBER <b>D16675</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W. Kline</b> <b>Frederick MD</b> <b>Brunswick MD 21716</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14826

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAROLD ADAMS</b>				2. Date of Death Month Day Year <b>May 13, 1996</b>		3. Time of Death <b>10:50 pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>1836 E. North Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>212-28-3502</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 28, 1931</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1836 E. North Avenue</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Night Watcher</b>			16b. Kind of Business/Industry <b>Baltimore City</b>				
	17. Father's Name (First, Middle, Last) <b>Walter Adams Adams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nanny Jones</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Haroldine Simpkins Simpkins</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1407 Dartmouth Ave., Baltimore, MD 21234</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Data <b>5-17-96</b>		20c. Location - City or Town, State <b>Woodlawn, MD</b>			
	21. Signature of Funeral Service Licensee <b>Bernard D Johnson</b>				22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Baltimore, MD 21202</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Cardiac Arrest</b> Due to (or as a consequence of):  b. <b>Ventricular tachycardia - Chronic</b> Due to (or as a consequence of):  c. <b>atherosclerotic coronary artery disease</b> Due to (or as a consequence of):  d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal failure on chronic dialysis</b> <b>Hypertension as original cause of kidney failure</b>								Approximate Interval Between Onset and Death  minutes  3 yrs  yrs	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office, building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Bayman Shabazz mb</b>		29c. License number <b>D24592</b>		29d. Date signed (Month, Day, Year) <b>05-16-96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1600 Chaima Hwy Ste 401 Glen Burnie MD. 21061</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14827

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hilda B. Ailiff

2. Date of Death

Month  
MayDay  
12Year  
1996

3. Time of Death

6:30 P.M.

4a. Facility Name (If not institution, give street and number)

3932 Pennington Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

184 05 3707

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 2, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3932 Pennington Avenue

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Motor Vehicle Adm.

17. Father's Name (First, Middle, Last)

Rodney Burdett

18. Mother's Name (First, Middle, Maiden Surname)

Catherine R. Cramer

19a. Informant's Name/Relationship (Type, Print)

Dorothy Lance

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1517 Poplin Street

Baltimore, Maryland 21226

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

5/16/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION  
Due to (or as a consequence of):b. ASCVD  
Due to (or as a consequence of):c. HYPERTENSION  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

023530

29d. Date signed (Month, Day, Year)

5-15-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ASHOK CHATTERJEE, 3927 ANNAPOLIS ROAD 21227

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14828

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GRACE ADDIS</b>				2. Date of Death Month <b>MAY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>5:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Meridian Nrsing Cntr. Hammonds Lane</b>				4b. City, Town, or Location of Death <b>Brooklyn Park</b>		4c. County of Death <b>Anne Arundel Co</b>	
Funeral Director	5. Social Security Number <b>219-05-4501</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 22, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3716 Elm Avenue</b>		10f. Zip Code <b>21211</b>		
10g. Citizen of What Country? <b>U.S.A</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Claims Examiner</b>		16b. Kind of Business/Industry <b>Maryland Casualty Co</b>		
17. Father's Name (First, Middle, Last) <b>Arlington Valdivia</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Armstrong</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Richard Addis (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13266 Rollie Road East, Bishopville, Md 21813</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valeey Mem Gdns</b>		20c. Location - City or Town, State <b>Timonium, Md</b>		20d. Date <b>5/22/96</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC UTERINE CARCINOMA 2 YEARS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D21776</b>		29d. Date signed (Month, Day, Year) <b>MAY 20 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURYA MUNDRA MD 203 E PATAPSCO AVE BALTIMORE</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

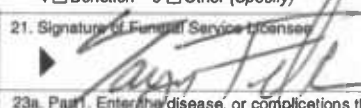
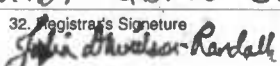
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EILEEN BAKER</b>				2. Date of Death Month <b>MAY</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>12:16 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MANOR CARE - RUXTON</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-44-1546</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 6, 1945</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RANDALLSTOWN</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3817 BRENTFORD RD.</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HEALTH CARE FINANCIAL ADMN.</b>			16b. Kind of Business/Industry <b>U.S. GOVERNMENT</b>	
17. Father's Name (First, Middle, Last) <b>AL HYATT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JULIA GOLDBERG</b>				
19a. Informant's Name/Relationship <b>MAURICE A. BAKER (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3817 BRENTFORD RD. RANDALLSTOWN, MD 21133</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NER TAMID</b>		Date <b>5/20/96</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Pancreatic Cancer</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>1 year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>M Boyle MD</b>				29c. License number <b>04161</b>		29d. Date signed (Month, Day, Year) <b>5/18/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Boyle, M.D. GBMC 6565 N. Charles St. Baltimore MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14830

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jean Blume</b>				2. Date of Death Month <b>MAY</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>9:00 AM</b>	
	4a. Facility Name (If not institution, give street end number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-01-2114</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 19, 1904</b>	
	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street end Number <b>2500 W. BELVEDERE AVE. #M-3</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Collega (1-4or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>ABRAHAM BLOCK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH ABRAMS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>HELEN GOLDBERG / SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3304 LEE COURT BALTIMORE, MD 21208</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BNAI ISRAEL</b>		Date <b>05/17/1996</b>		20c. Location - City or Town, State <b>BALTIMORE</b>		
21. Signature of Funeral Service Licensee <i>Joy Alan Lewis</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Bilateral Lower Lung Pneumonia</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>J. Baezmo - Resident</i>				29c. License number <b>AS2402321-JB/9701</b>		29d. Date signed (Month, Day, Year) <b>May 15, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jorge L. Baez Sinai Hospital / Baltimore City Maryland.</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14831

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZARETH K. BEACHAM</b>				2. Date of Death Month <b>5</b> Day <b>14</b> Year <b>96</b>		3. Time of Death <b>12:40PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Caton Manor Nursing Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217 03 4914</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>3119 Bero Road</b>								
10f. Zip Code <b>21227</b>								
10g. Citizen of What Country? <b>U.S.</b>								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced								
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:								
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)								
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>								
16b. Kind of Business/Industry <b>In own home</b>								
17. Father's Name (First, Middle, Last) <b>Archie Dougherty</b>								
18. Mother's Name (First, Middle, Maiden Summa) <b>(unknown) Lintz</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Henry Beacham</b>								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2737 Yarnall Road Baltimore, Maryland 21227</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)								
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>								
20c. Location - City or Town, State <b>5/16/96 Baltimore, Maryland</b>								
21. Signature of Funeral Service Licensed <b>Gonce Funeral Home P.A.</b>								
22. Name and Address of Facility <b>4001 Ritchie Highway Baltimore, Md. 21225</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Emphysema</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>1 day</b> <b>20 yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>carcinoma Uterus</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Julia Pearson-Ross</b>								
29c. License number <b>D25044</b>								
29d. Date signed (Month, Day, Year) <b>5/15/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. J. Pearson-Ross MD 2717 Krumm and Perry Rd BALTO MD 21227</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>								
32. Registrar's Signature <b>BALTO MD 21227</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505-555-5555.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14832

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Abraham C. Berkowitz</u>		2. Date of Death Month <u>May</u> Day <u>15</u> Year <u>1996</u>		3. Time of Death <u>8:25 AM.</u>
	4a. Facility Name (If not institution, give street and number) <u>410 Yeshiva Lane</u>		4b. City, Town, or Location of Death <u>Baltimore,</u>		4c. County of Death <u>Baltimore</u>
Funeral Director	5. Social Security Number <u>567-40-6371</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>July 4, 1913</u>		9. Birthplace (State or Foreign Country) <u>Poland</u>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <u>MD</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>410 Yeshiva Lane</u>		10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Proprietor</u>	
16b. Kind of Business/Industry <u>Foodstuff</u>		17. Father's Name (First, Middle, Last) <u>Mordachai Berkowitz</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Perel Rosen</u>	
19a. Informant's Name/Relationship (Type, Print) <u>Rajzla Berkowitz (Spouse)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>410 Yeshiva Lane Baltimore, MD 21208</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Agudath Israel</u>		20c. Location - City or Town, State <u>05/15/96 Rosedale, MD</u>	
21. Signature of Funeral Service Licensee <u>Jay Alan Lewis</u>		22. Name and Address of Facility <u>Sol Levinson &amp; Bros., Inc.</u> <u>8900 Reisterstown Road Baltimore, MD 21208</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. RESPIRATORY FAILURE</u> Due to (or as a consequence of): <u>b. METASTATIC COLON CANCER</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>		Approximate Interval Between Onset and Death <u>IMMEDIATE</u> <u>6 MONTH</u>			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Julian Jankowski MD</u>		29c. License number <u>D25034</u>	
29d. Date signed (Month, Day, Year) <u>5.15.96</u>		30. Name and address of person who completed cause of death (item 23e) (Type, Print) <u>JULIAN JANKOWSKI MD 6503 PARK HEIGHTS AVE BALTIMORE MD 21215</u>			
31. Date filed (Month, Day, Year) <u>MAY 21 1996</u>		32. Registrar's Signature <u>John Shuster Randall</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

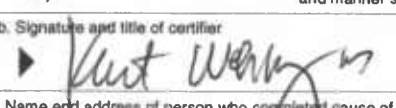
Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14833

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Robert J Bowden</b>					2. Date of Death Month Day Year <b>MAY 19, 1996</b>		3. Time of Death <b>13:53</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE, MD</b>		4c. County of Death <b>BALTIMORE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>045-24-5175</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 13, 1933</b>		9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>21306 Virginia Avenue</b>			10f. Zip Code <b>21620</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Caterer</b>			16b. Kind of Business/Industry <b>Food Service</b>		
17. Father's Name (First, Middle, Last) <b>Robert James Bowden Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Alexandria E. Williams</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Doris Lorraine Bowden</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21306 Virginia Ave. Chestertown, MD 21620</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>5/21</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. <u>Enter only one cause on each line.</u>									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>multisystem organ failure</b> Due to (or as a consequence of):									
b. <b>Liver resection</b> Due to (or as a consequence of):									
c. <b>colon cancer</b> Due to (or as a consequence of):									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D46536</b>		29d. Date signed (Month, Day, Year) <b>5/14/96</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Kurt Wehberg (Resident), University Maryland Hospital</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268-0760  
 To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 29c, 30, PER FIELD REP.

State of Maryland / Department of Health and Mental Hygiene

96 14834

FILM G-735 5/21/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN R. BEADLING</b>				2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>0930 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>--- N/A ---</b>	
Funeral Director	5. Social Security Number <b>220-36-6850</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 1, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Pa.</b>		10a. State <b>Md.</b>		10b. County <b>----- N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>700 W. 40th. St.</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered nurse</b>		16b. Kind of Business/Industry <b>Medical</b>		17. Father's Name (First, Middle, Last) <b>Homer G. Beadling</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Ellen Mackey</b>		19a. Informant's Name/Relationship (Type, Print) <b>Edward A. Johnston/Pers. Rep.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 W. Pennsylvania Ave. Towson, Md. 21204</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oakspring Cemetery</b>		20c. Location - City or Town, State <b>5/22/96 Canonsburg, Pa.</b>		21. Signature of Funeral Service Licensee <b>John O. Mitchell II</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto. Md. 21212</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Myocardial Infarction</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>* 4 hrs</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SUBDURAL HEMATOMA</b> <b>SUBARACHNOID HEMATOMA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <b>John O. Mitchell II</b>		29c. License number <b>P07525</b>		29d. Date signed (Month, Day, Year) <b>May 16, 1996</b>		30. Name and address of person who completed cause of death form (Type, Print) <b>22 S. GREENE STREET BALTIMORE, MARYLAND</b>		
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <b>John Andrew Randall</b>		State Registrar		DHHM 16 Rev 6/95		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be submitted for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14835

Film G735 item 8 per FH 5-23-96 rja Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SUSAN CLAIRE BILENKI				2. Date of Death Month Day Year MAY 18, 1996		3. Time of Death 10:15 AM	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-50-8166		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-09-1947	9. Birthplace (State or Foreign Country) NEW JERSEY
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 205 OLD ENGLISH OAK COURT				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry REAL ESTATE			
	17. Father's Name (First, Middle, Last) AUTHUR LENNON ANDERS				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY KOZLOWSKI			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PAUL ALEXANDER BILENKI				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 OLD ENGLISH OAK CT., LINTHICUM, MD. 21090			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		Date 5/22/96		20c. Location - City or Town, State ELKBRIDGE, MD.	
	21. Signature of Funeral Service Licensee <i>Michael C. Zaffron</i>				22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>CARDIAC ARREST</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pericardial Pacing</i> <i>MI P Supraventricular Tachycardia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Frank Morris</i>				29c. License number <i>D 18406</i>		29d. Date signed (Month, Day, Year) <i>5-20-96</i>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>FRANK MORRIS MD, SUITE 409 UDEMED BLD TOWSON MD 21204</i>							
	31. Date filed (Month, Day, Year) <i>MAY 21 1996</i>				32. Registrar's Signature <i>Julia Gordon-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



5/21/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14836

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEWIS COLEMAN BARBOUR</b>				2. Date of Death Month <b>MAY</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>2:40 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-03-0207</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 4, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>COCKEYSVILLE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1240 Paper Mill Rd.</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Artist</b>		16b. Kind of Business/Industry <b>n/a</b>		17. Father's Name (First, Middle, Last) <b>James C. Barbour</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Eaton</b>		19a. Informant's Name/Relationship (Type, Print) <b>Claude E. Barbour</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13704 E. Devonfield Drive, Baldwin, MD 21013</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Poplar Grove Cemetery</b>		20c. Date <b>20 MAY</b>		20d. Location - City or Town, State <b>Cockeysville, MD</b>		21. Signature of Funeral Service Licensee <i>Lowell M. Lemmon</i>		
22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. METASTATIC PROSTATE CANCER</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>1 1/2 YEARS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>Beatriz P. Dizon, M.D.</i>		29c. License number <b>D16492</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>BEATRIZ P. DIZON, M.D., ST. JOSEPH MEDICAL CENTER, TOWSON, MD. 21204</b>		
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>John A. ...</i>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14837

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED CARAWAY</b>				2. Date of Death Month <b>MAY</b> Day <b>15</b> Year <b>96</b>		3. Time of Death <b>3-55 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hosp</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-20-9986</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (Yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7-17-1923</b>	
	9. Birthplace (State or Foreign Country) <b>md.</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1300 Washington Blvd.</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINIST</b>		16b. Kind of Business/Industry <b>Hand &amp; BAKEY</b>		17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>		19a. Informant's Name/Relationship (Type, Print) <b>MR. LORENZO CARAWAY</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1300</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION Cem</b>		20c. Location - City or Town, State <b>5/21</b>		21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>JOSEPH L. RUSS FUNERAL HOME 2222 W. NORTH AVE. BALTIMORE MD 21216</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure due to</b> Due to (or as a consequence of): <b>b. Metastasis (to Brain) Carcinoma 3 Month</b> Due to (or as a consequence of): <b>c. of lungs.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>1 DAY.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>R. M. Shah MD.</b>	
	29c. License number <b>D19668</b>		29d. Date signed (Month, Day, Year) <b>MAY 17 96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>R. M. SHAH, BON SECOURS HOSPITAL.</b>		31. Data filed (Month, Day, Year) <b>MAY 21 1996</b>	
32. Registrar's Signature <b>J. Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

96 14838

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH Agnes CARTER</b>				2. Date of Death Month Day Year <b>MAY 20, 1996</b>		3. Time of Death <b>9:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>213-05-8224</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 5, 1908</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>2300 Dulaney Valley Road</b>			10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>William Charles Russell</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Tamazon Agnes Beck</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Tamazon L. Stevenson</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 Northwood Drive, Timonium, MD 21093</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>May 22</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>		
	21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>			22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Acute Myocardial Infarction 1-24 hrs.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>J. Carroll M.D.</b>		29c. License number <b>D26510</b>		29d. Date signed (Month, Day, Year) <b>5/20/96 945 PM</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>D. Carroll G-BMC E.R. 6701 N. Charles St., Towson, MD 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14839

ITEMS: 23 PART I, 27 per MEO 6-736 6/26/96 **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANN Catherine CHRISTIANSEN</b>				2. Date of Death Month Day Year <b>MAY 17, 1996</b>		3. Time of Death <b>0440 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>			
Funeral Director	5. Social Security Number <b>212-98-0014</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 7, 1977</b>		9. Birthplace (State or Foreign Country) <b>Sweden</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Harwood</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>4443 Owensville Sudley Road</b>			10f. Zip Code <b>20776</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>			16b. Kind of Business/Industry <b>School</b>				
	17. Father's Name (First, Middle, Last) <b>Kim Allen Christiansen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Margrethe Holm</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Kim Allen Christiansen</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4443 Owensville Sudley Rd. Harwood, MD 20776</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Data <b>5/20</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CARDIAC ARRHYTHMIA</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient XX <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MAY 17, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodore M. King</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>					32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

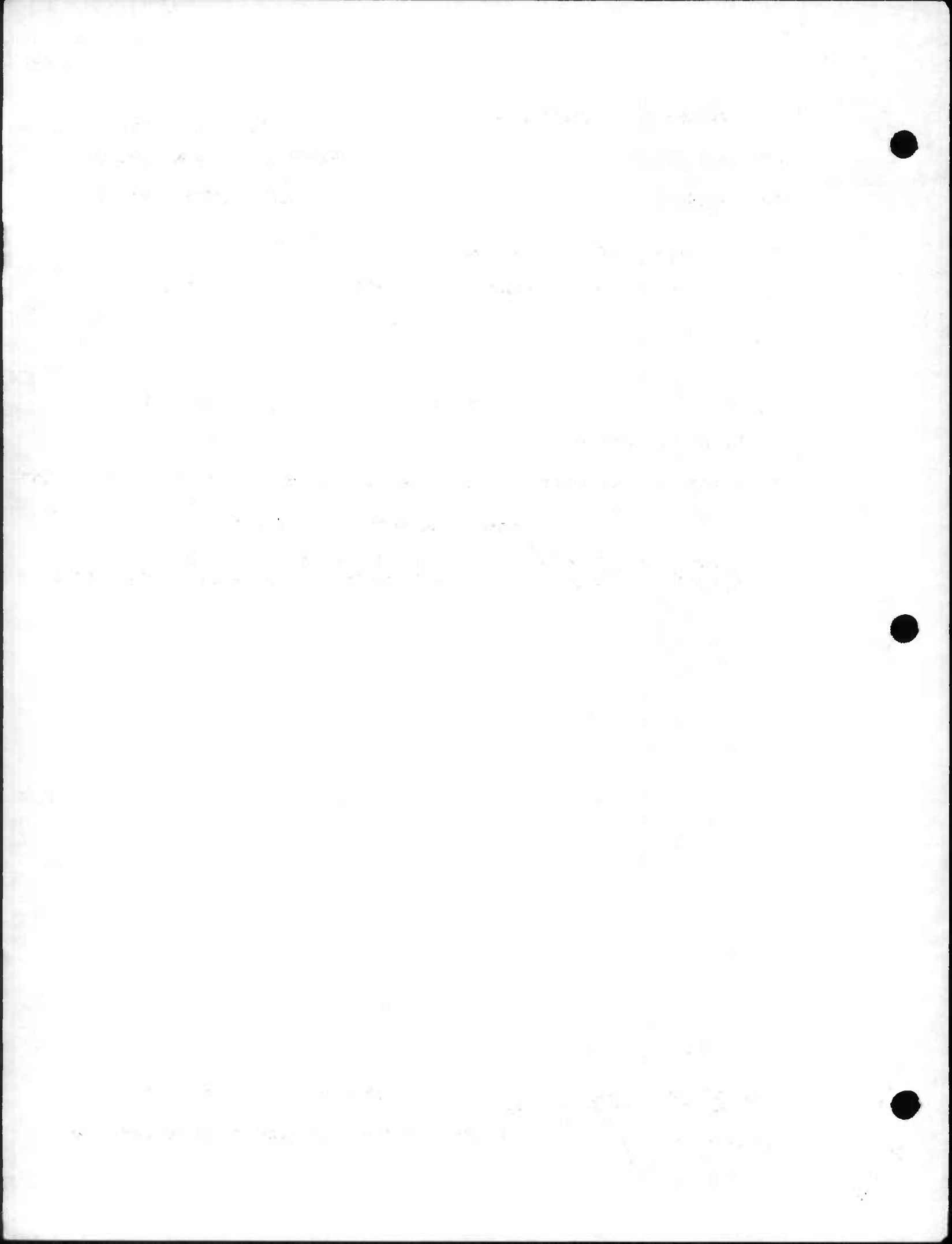
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14840

## Certificate of Death

Reg. No.

Item: 8, per F.H. G-735 5/28/96 reb

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLENE CRAWFORD</b>		2. Date of Death Month <b>MAY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>3:37 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>UMMS</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>218-64-0373</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>40</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>10/29/55</b>		9. Birthplace (State or Foreign Country) <b>Baltimore</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1107 North Calhoun St.</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>NA</b>	
17. Father's Name (First, Middle, Last) <b>John L. Carter</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Neal Carter</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Stephanie Anderson - Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21217</b> <b>1107 North Calhoun Street Baltimore, MD</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. Location - City or Town, State <b>5-2446 Catonsville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Albert P. Wylie F/H.P.A.</b> <b>638 N. Gilman Street 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not antart the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
e. <b>CEREBRAL HERNIATION SYNDROME</b>					
Due to (or as a consequence of):					
b. <b>ANEURYSMAL SUBARACHNOID HEMORRHAGE</b>					
Due to (or as a consequence of):					
c. _____					
Due to (or as a consequence of):					
d. _____					
Approximate Interval Between Onset and Death <b>4 DAYS</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>7301</b>		29d. Date signed (Month, Day, Year) <b>MAY 19, 1996</b>	
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>22 GROVEN ST. BALTIMORE MD 21201. DAVID H. HARTER MD.</b>					
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar




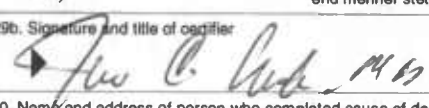
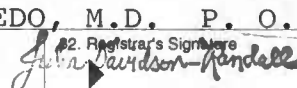
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14841

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Paul Campbell</b>				2. Date of Death Month <b>May</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>1 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County Gen. Hosp.</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>198-30-2088</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 3, 1938</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Manchester</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4605 Wentz Rd.</b>				10f. Zip Code <b>21102</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1956-1962</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>President</b>			16b. Kind of Business/Industry <b>Pharmacy Lab.</b>	
17. Father's Name (First, Middle, Last) <b>Walter Campbell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Chapel</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary J. Campbell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4605 Wentz Rd., Manchester, Md. 21102</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hampstead Cem. May 22, 1996</b>		20c. Location - City or Town, State <b>Hampstead, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102</b>				
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CARDIAC RESPIRATORY ARREST</b> Due to (or as a consequence of):  b. <b>MYO CARDIAL INFARCTION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death  <b>2 HRS.</b>  <b>3-4 HRS.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>HYPERLIPIDEMIA</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D08242</b>		29d. Date signed (Month, Day, Year) <b>5-20-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOSUE C. LAREDO, M.D. P. O. BOX 165, HAMPSTEAD, MD 21074</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

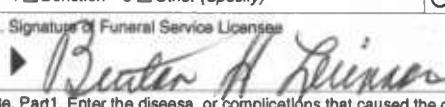
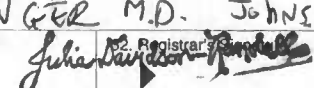




**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14842

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARVIN DOUGLAS</b>					2. Date of Death Month Day Year <b>MAY 17, 1996</b>		3. Time of Death <b>9:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3601 CLARKES LANE APT. 514</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>219-16-5081</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 22, 1925</b>		9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3601 CLARKES LANE APT. 514</b>					10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRIETOR</b>			16b. Kind of Business/Industry <b>PACKAGE LIQUOR</b>		
17. Father's Name (First, Middle, Last) <b>HARRY DOUGLAS</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL BADLER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ELAINE DOUGLAS / SPOUSE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3601 CLARKES LANE #514 BALTIMORE, MD 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHIZUK AMUNO (ARLINGTON)</b>			Date <b>05/19/1996</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Non-small Cell Lung Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>David S. Ettinger M.D. attending</b>			29c. License number <b>D17207</b>		29d. Date signed (Month, Day, Year) <b>5/17/96</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVID S. ETTINGER M.D. Johns Hopkins Oncology Ctr Balt MD 21287</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

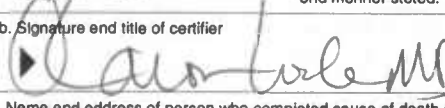
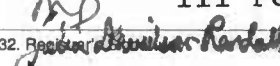
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES L. DUDLEY Jr.</b>		2. Date of Death Month <b>14</b> Day <b>1996</b> Year		3. Time of Death <b>5:50 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>1006 N. PRESTON ST.</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-64-2616</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 3, 1957</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1006 E. Preston Street</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Unknown</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) <b>James L. Dudley, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Salley Dudley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Evangelist Salley Dudley</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1006 E. Preston Street, Baltimore, MD 21202</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park Cem.</b>		20c. Location - City or Town, State <b>5-20-96 Randallstown, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier  <b>J. A. Ron Locke MD</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. A. Ron Locke MD 111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

67

1940  
The first of the year  
was a very dry one  
and the crops were  
very poor. The  
weather was very  
hot and the  
crops were very  
poor. The  
weather was very  
hot and the  
crops were very  
poor.

The second of the year  
was a very wet one  
and the crops were  
very good. The  
weather was very  
cool and the  
crops were very  
good.

The third of the year  
was a very dry one  
and the crops were  
very poor. The  
weather was very  
hot and the  
crops were very  
poor.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14844

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marcela M. de Vera				2. Date of Death Month Day Year May 17 1996		3. Time of Death 2:00 A.M.	
	4a. Facility Name (If not institution, give street and number) Allegis Nursing Home				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216 88 1380	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 29, 1912		9. Birthplace (State or Foreign Country) Philippines
	Usual Residence of Decedent							
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Linthicum			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6218 Chestnut Oak Lane				10f. Zip Code 21090		10g. Citizen of What Country? Philippines		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) (unknown)				18. Mother's Name (First, Middle, Maiden Surname) (unknown)				
19e. Intormant's Name/Relationship (Type, Print) Esther Atienza				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6218 Chestnut Oak Lane Linthicum, Maryland 21090				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 5/20/96		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Donna M. Zamiroushi				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225				
23a. Pert 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 30 MINUTES Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION DEMENTIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ATTENDING		29c. License number D21776		29d. Date signed (Month, Day, Year) MAY 20 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURYA MUNDRA MD 203 E CATARSCO AVE BALTIMORE 21225								
31. Date filed (Month, Day, Year) MAY 21 1996		32. Registrar's Signature John Davidson-Randall						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14845

Item 7, File 737, 7/10/96, 1t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETTA T. DRAPER				2. Date of Death Month Day Year May 18, 1996				3. Time of Death 9:50 P.M.						
	4a. Facility Name (If not institution, give street and number) Longview Nursing Home				4b. City, Town, or Location of Death Manchester				4c. County of Death Carroll						
Funeral Director	5. Social Security Number 237-34-8512		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) APRIL 16, 1902		9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent														
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Owings Mills						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 79 Ritters Lane				10f. Zip Code 21117				10g. Citizen of What Country? USA							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High School				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Rosewood				16b. Kind of Business/Industry Cook							
17. Father's Name (First, Middle, Last) Zeke Tipton				18. Mother's Name (First, Middle, Maiden Surname) Millie Gouge											
19a. Informant's Name/Relationship (Type, Print) Mrs. Betty J. Littleton (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Ritters Lane Owings Mills, Md. 21117											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial				Data 5/21/96		20c. Location - City or Town, State Finksburg, Md.					
21. Signature of Funeral Service Licensee <i>Sam B. E. Line</i>				22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, Md. 21136											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														Approximate interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)														1 week	
a. <i>Aspiration pneumonia</i>														Due to (or as a consequence of):	
b. <i>Recurrent Cerebral Vascular accident</i>														10 days	
c.														Due to (or as a consequence of):	
d.														Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
<i>Diabetes Mellitus - Senile Dementia</i>															
<i>Coronary artery Heart Disease</i>															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Wilbur Foard MD</i>				29c. License number D02386				29d. Date signed (Month, Day, Year) 5/19/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilbur Foard M. D. 3223 N. Main Street Manchester, Md. 21102															
31. Date filed (Month, Day, Year) MAY 21 1996				32. Registrar's Signature <i>John Anderson-Rendell</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14846

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Bernadette L. DOYLE</b>						2. Date of Death Month <b>May</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>9:58 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>						4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>	
<b>Funeral Director</b>	5. Social Security Number <b>215-12-5149</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 28, 1919</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>820 N. Marlyn Ave.</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Key Punch</b>			16b. Kind of Business/Industry <b>Aircraft</b>			
17. Father's Name (First, Middle, Last) <b>William Forney</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Fogarty</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kathy Cramer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>507 S. Main Street Shrewsburg PA. 17361</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		Date <b>5/22/96</b>		20c. Location - City or Town, State <b>Rossville Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Atherosclerotic Cardiovascular Disease</b></p> <p>Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> <p><b>30 years</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D27315</b>		
				29d. Date signed (Month, Day, Year) <b>5-18-96</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. M. L. Frydenborg 9000 Franklin Square Drive Baltimore, Maryland 21237</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

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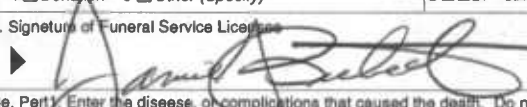
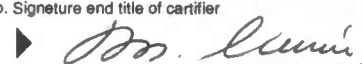
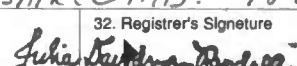
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14847

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES HERMAN DILUCA SR.</b>				2. Date of Death Month Day Year <b>MAY 18, 1996</b>		3. Time of Death <b>7:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>913 LANGLEY ROAD</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>102-14-5163</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12-02-1921</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>							
Usual Residence of Decedent								
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street end Number <b>913 LANGLEY ROAD</b>				10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>1942-</b> If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>			16b. Kind of Business/Industry <b>RAIL ROAD</b>	
17. Father's Name (First, Middle, Last) <b>SAMUEL DILUCANTONIO</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>URSULA STELLA AGNES SHAD</b>				
19a. Informant's Name/Relationship (Type, Print) <b>HENRIETTA H. DILUCA</b>				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <b>913 LANGLEY ROAD, GLEN BURNIE, MD. 21060</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		Date <b>5/21/96</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma of Lung</b> Due to (or as a consequence of) <b>b. Chronic obstructive pulmonary disease</b> Due to (or as a consequence of) <b>c.</b> Due to (or as a consequence of) <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>6 months</b> <b>5 yrs.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street end Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D40519</b>		29d. Date signed (Month, Day, Year) <b>5.20.96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MIRZA M. NUSAIRRE MD. 7845 OAKWOOD Rd Glen Burnie md. 21061</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

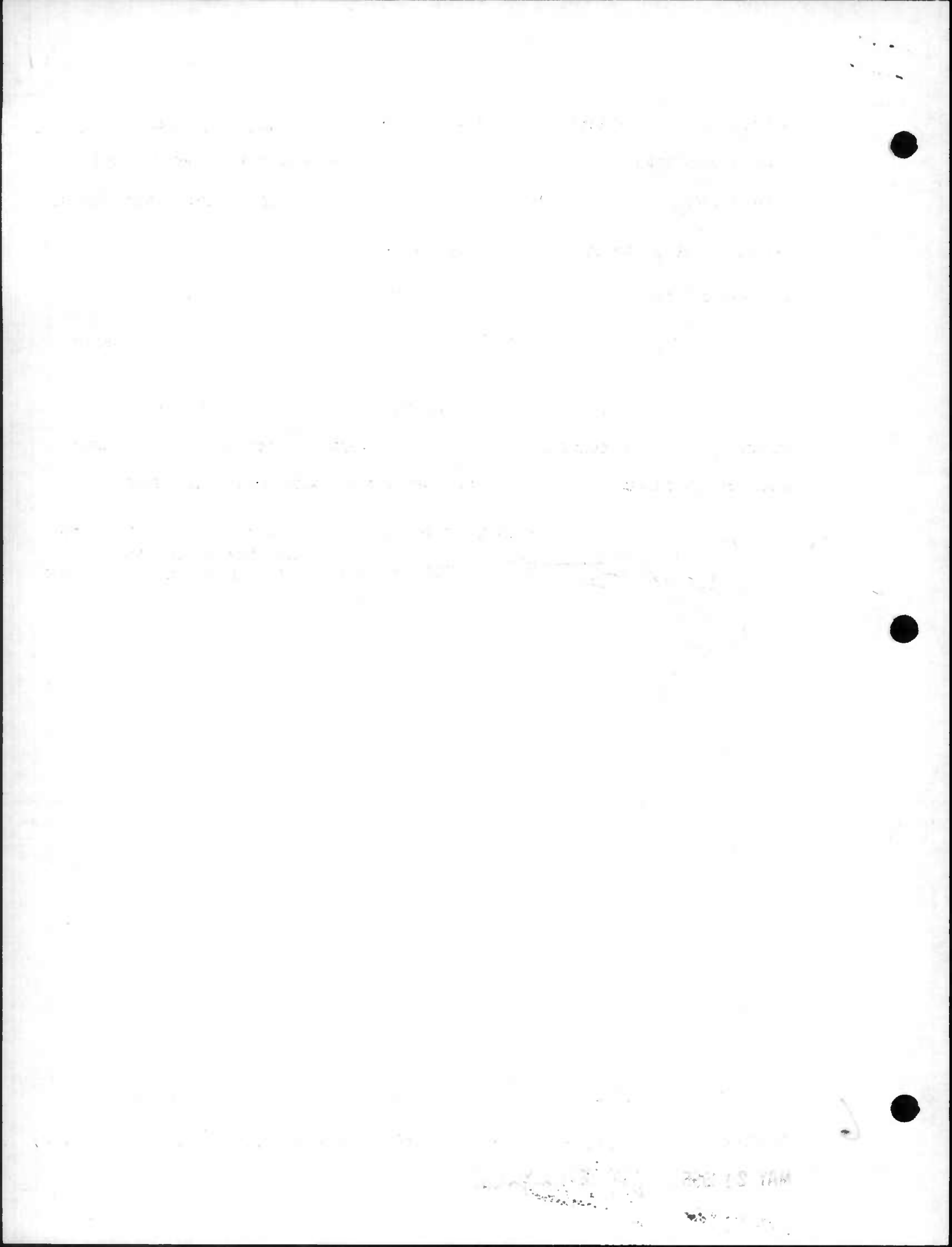
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

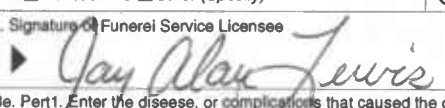
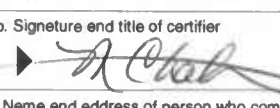
State Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14848

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Leonard H. FLAX</b>					2. Date of Death Month Day Year <b>May 16, 1996</b>		3. Time of Death <b>1:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore County</b>	
<b>Funeral Director</b>	5. Social Security Number <b>340-14-4212</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 5, 1925</b>		9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RANDALLSTOWN</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8917 LIBERTY ROAD</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SURGEON</b>			16b. Kind of Business/Industry <b>MEDICAL</b>		
17. Father's Name (First, Middle, Last) <b>ABRAHAM W. FLAX</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>YETTA E. LEVY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>PHYLLIS FLAX / SPOUSE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8917 LIBERTY ROAD RANDALLSTOWN, MD 21133</b>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREATER BALTIMORE LODGE</b>		Date <b>5/19/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Chronic Infection</u> Due to (or as a consequence of):</p> <p>b. <u>Morbid Obesity</u> Due to (or as a consequence of):</p> <p>c. <u>Diabetes</u> Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>3 weeks</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Chronic Renal Insufficiency, Sleep Apnea, Emphysema</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number <b>D20907</b>		29d. Date signed (Month, Day, Year) <b>5/16</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marie Chatham, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14849

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda Lynn Funkhouser

2. Date of Death

Month  
May

Day

16

Year

1996

3. Time of Death

5:46 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

218 44 6560

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 5, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1451 Brewer Neck Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurant Owner

16b. Kind of Business/Industry

Self employed

17. Father's Name (First, Middle, Last)

Robert Dickson

18. Mother's Name (First, Middle, Maiden Surname)

Frances Wojcik

19a. Informant's Name/Relationship (Type, Print)

Nick Funkhouser

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1451 Brewer Neck Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

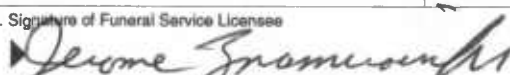
Date

5/20/96

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASCUD

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

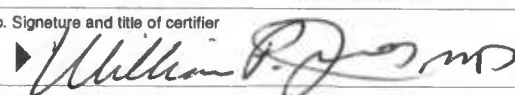
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D06054

29d. Date signed (Month, Day, Year)

5/20/96

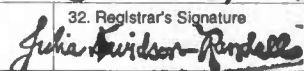
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14850

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>YETTA</b>				2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1996</b>				3. Time of Death <b>9:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>OLD COURT NURSING HOME</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-50-3965</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>MAR. 14, 1900</b>		9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		Usual Residence of Decedent		10e. State <b>MD</b>		10b. County <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>RANDALLSTOWN</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5412 OLD COURT RD.</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>AARON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELLA MEYERSON</b>		19a. Informant's Name/Relationship (Type, Print) <b>MRS. RAE BAZENSKY (DAUG.)</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 CANDLEMAKER CT., APT. 202 BALTO., MD 21208</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OHEL YAKOV-BETH ISRAEL</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		21. Signature of Funeral Service Licensee <i>Joel D. Lewis</i>	
	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Cardiovascular Accident</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5 14 96</b>		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>DO 4299</b>		29d. Date signed (Month, Day, Year) <b>5/14/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Howard J. Garber, MD 5310 Old Court Rd Randallstown, MD 21133</b>		31. Date filed (Month, Day, Year) <b>21 1996</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film G735 item 3 Per DR. %-21-96 rja

## Certificate of Death

Reg. No.

96 14851

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Franklin				2. Date of Death Month Day Year May 14, 1996		3. Time of Death 10:42 A.M.	
	4a. Facility Name (If not institution, give street and number) 3701 Woodbine Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-36-7798		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 6, 1940	9. Birthplace (State or Foreign Country) Va
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 3701 Woodbine Avenue				10f. Zip Code 21207		10g. Citizen of What Country? U S A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 10th grade N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician		16b. Kind of Business/Industry Sears Service Center			
	17. Father's Name (First, Middle, Last) Robert C. Oliver				18. Mother's Name (First, Middle, Maiden Surname) Esther Jeffries			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Deborah Browne- Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 N. Mount Street Baltimore, Md 21217			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 5-18-96 Randallstown, Md			
	21. Signature of Funeral Service Licensee Jerome A Thompson				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastric Cancer Squamous cell Due to (or as a consequence of): b. Liver metastasis Due to (or as a consequence of): c. Hyperthyroidism Due to (or as a consequence of): d. Cardio pulmonary arrest							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Attending Phys		29c. License number D30115	
	29d. Date signed (Month, Day, Year) 5/15/96							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Ohiokpehai, MD 2600 Liberty Halls Ave Bait, MD 21215							
31. Date filed (Month, Day, Year) MAY 21 1996				32. Registrar's Signature J. Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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ITEMS: 10e, 12, PER F.H. FILM  
6-735 5/21/96 t.tState of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 14852

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICK PATRICK FRANKE</b>			2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>4:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. JOSEPH MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-28-2766</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 7, 1933</b>
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALDWIN</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>DAIRYDALE 14300 Dairy Dale Rd.</b>				10f. Zip Code <b>21013</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>n/a</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor-Customer Service</b>		16b. Kind of Business/Industry <b>B G &amp; E (Utilities)</b>	
17. Father's Name (First, Middle, Last) <b>Frederick Patrick Franke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emily Camille Roberto</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Nancy M. Franke</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14300 Dairydale Rd., Baldwin, MD 21013</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's, Longreen</b>		20c. Location - City or Town, State <b>Baldwin, MD</b>		20d. Date <b>MAY 20</b>	
21. Signature of Funeral Service Licensed <b>Bryan W. Clary</b>		22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>CEREBRAL EDEMA</b></p> <p>Due to (or as a consequence of): <b>CORONARY ARTERY BYPASS SURGERY</b></p> <p><b>ISCHEMIC HEART DISEASE</b></p> </div> <div style="width: 15%;"> <p><b>1 HOUR</b></p> <p><b>5 HOURS</b></p> <p><b>20 YEARS</b></p> </div> </div>							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D 44080</b>		29d. Date signed (Month, Day, Year) <b>5-17-96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Francis Varga, M.D., 7620 York Road, Towson, Maryland 21204</b>							
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death



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State of Maryland / Department of Health and Mental Hygiene

96 14853

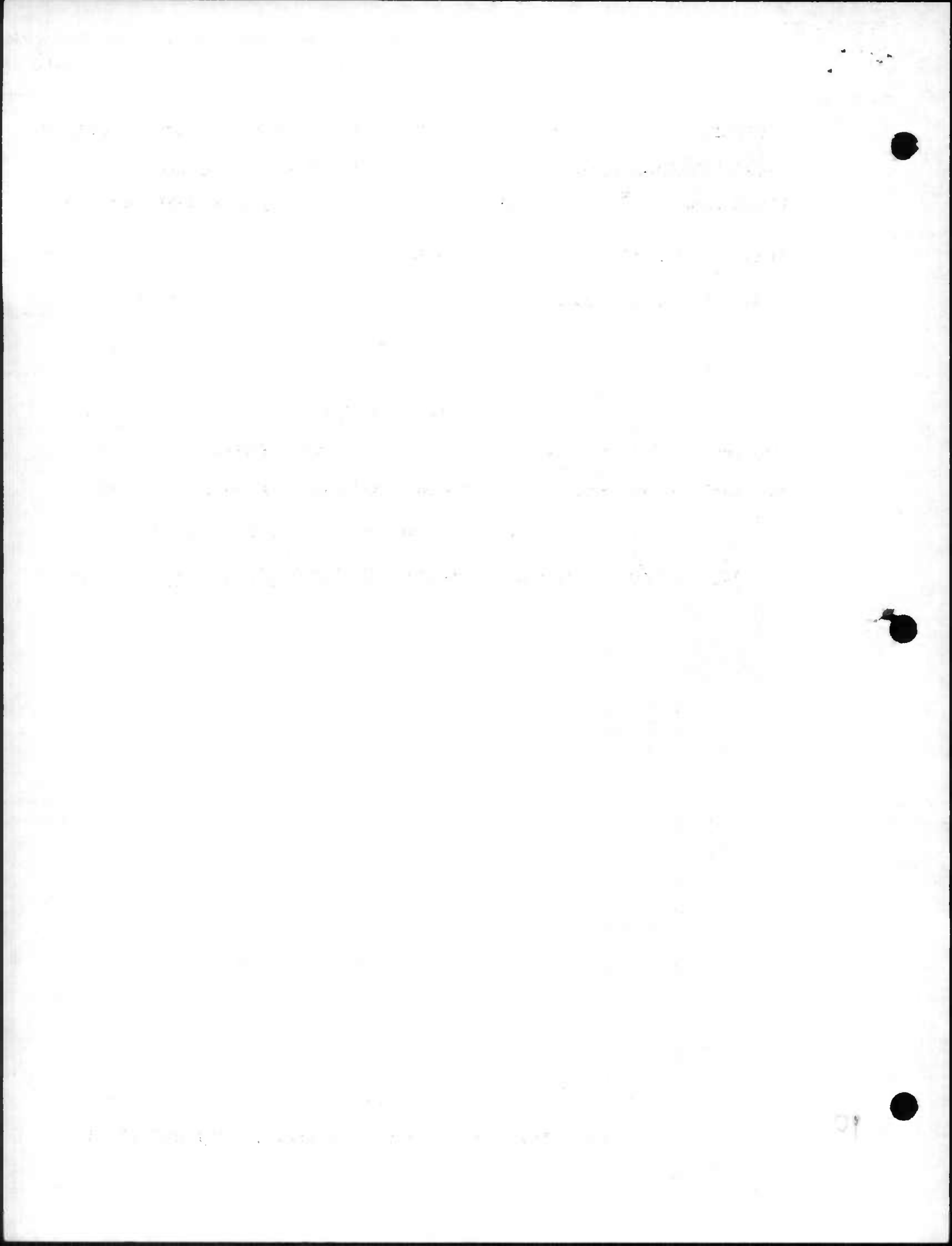
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES EDWARD FREYMAN, JR.</b>					2. Date of Death Month Day Year <b>MAY 18 1996</b>		3. Time of Death <b>4:13 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>7421 VILLAGE ROAD</b>					4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>214-66-7336</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 20, 1957</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>7421 Village Road Apt. 22</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Analyst</b>			16b. Kind of Business/Industry <b>BGE</b>		
	17. Father's Name (First, Middle, Last) <b>Charles E. Freyman Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy Kimbelton</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Father</b> <b>Mr. Charles E. Freyman, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>830 Templecliff Road Pikesville, MD 21208</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>5/22</b>		20c. Location - City or Town, State <b>Woodlawn, MD</b>		
	21. Signature of Funeral Service Licensee <i>James B. Cooper</i>				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Contact Gun shot wound of chest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-18-96</b>		28b. Time of Injury <b>1613</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject shot self</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 19, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 14854

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Ruth I. Fleming</u>				2. Date of Death Month <u>May</u> Day <u>17</u> Year <u>1996</u>		3. Time of Death <u>12:40 pm</u>								
	4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital 2401 Belvedere</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore</u>								
Funeral Director	5. Social Security Number <u>185-28-4242</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>60</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Jan 7, 1936</u>								
	10a. State <u>MD</u>		10b. County <u>Baltimore Co.</u>		10c. City, Town or Location <u>Reisterstown</u>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Usual Residence of Decedent															
10e. Street and Number <u>205 Erin Way</u>				10f. Zip Code <u>21136</u>		10g. Citizen of What Country? <u>USA</u>									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>white</u>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Funeral Director</u>			16b. Kind of Business/Industry <u>Funeral</u>								
17. Father's Name (First, Middle, Last) <u>Lester L. Hilker</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Esther Forry</u>											
19a. Informant's Name/Relationship (Type, Print) <u>E. Barnes Fleming/Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>205 Erin Way Unit 102 Reisterstown, MD 21136</u>											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Christ UCC Cemetery</u>		Date <u>5/21/96</u>		20c. Location - City or Town, State <u>Littlestown, PA</u>								
21. Signature of Funeral Service Licensee <u>Eline B. Schmitt</u>				22. Name and Address of Facility <u>11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136</u>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Breast CA.</u> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <u>2 yrs.</u></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b.  Due to (or as a consequence of):</td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. <u>Breast CA.</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>2 yrs.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <u>Breast CA.</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>2 yrs.</u>													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):														
	c. Due to (or as a consequence of):														
	d. Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred									
			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <u>Valerie Serna MD.</u>				29c. License number <u>AS 2402321 VS 2931</u>		29d. Date signed (Month, Day, Year) <u>May 17, 1996</u>									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>2401 Belvedere Ave. Baltimore, MD.</u>															
31. Date filed (Month, Day, Year) <u>MAY 21 1996</u>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14855

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MATILDA OLIVIA FEATHERS</b>						2. Date of Death Month <b>05</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>1:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE CENTER</b>						4b. City, Town, or Location of Death <b>SEVERNA PARK</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
<b>Funeral Director</b>	5. Social Security Number <b>217-16-7864</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01-05-1900</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE, MARYLAND</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>327 WILSON BLVD.</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>			
17. Father's Name (First, Middle, Last) <b>JOHN W. THIESS</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MATILDA REBEL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>RUTH E. SOCKRITER (DAUGHTER)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>327 WILSON BLVD., GLEN BURNIE, MD, 21061</b>					
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		Date <b>5/20/96</b>		20c. Location - City or Town, State <b>BROOKLYN, MARYLAND</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>acute myocardial infarction</b> Due to (or as a consequence of):</p> <p>b. <b>atherosclerotic heart disease</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate interval Between Onset and Death</p> <p><b>Immediate</b></p> <p><b>Years</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D25611</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRA E. KAPLAN M.D. 7845 Oakwood Rd #300 Glen Burnie Maryland 21061</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020  
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14856

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NETTIE GOULD</b>				2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>2:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>6317 PARK HEIGHTS AVE., APT. 320</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-12-9079</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 23, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>								
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>6317 Park Heights Ave. Apt. 320</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>David Perlman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Shapiro</b>					
19a. Informant's Name/Relationship (Type, Print) <b>David P. Gould / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 E. Joppa Road Suite 407 Towson, MD 21286</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anshe Emunah (Aitz Chaim) 5/16/96 Baltimore, MD</b>			Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head injury. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Congestive heart failure</b> Due to (or as a consequence of): <b>Aortic valve disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 year</b> <b>20 years</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D15561</b>		29d. Date signed (Month, Day, Year) <b>5/14/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>7401 Oster Jr Baltimore, md 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

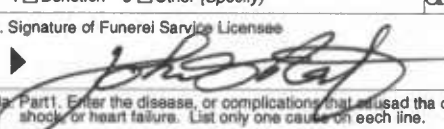
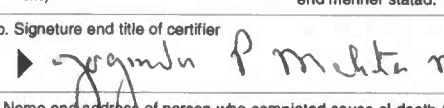
State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14857

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARGUERITE MAE GARTON</b>						2. Date of Death Month Day Year <b>MAY 19, 1996</b>		3. Time of Death <b>9:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>212-05-0194</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 13, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>302 E. Joppa Road</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>Telephone Company</b>			
17. Father's Name (First, Middle, Last) <b>Theodore Edward Gengnagel</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Marguerite Lins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ernest F. Ohler/brother-in-law</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>423 Chumleigh Road, Baltimore, Maryland 21212</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chestnut Grove Presbyterian Church 5/23</b>		20c. Location - City or Town, State <b>Phoenix, Maryland</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>e. UROSEPSIS</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>2 DAYS</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PERIPHERAL VASCULAR DISEASE</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number <b>D 41410</b>		29d. Date signed (Month, Day, Year) <b>MAY 20th, 96.</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOGINDER P. MEHTA, MD 7620 YORK ROAD TOWSON, MARYLAND 21204</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

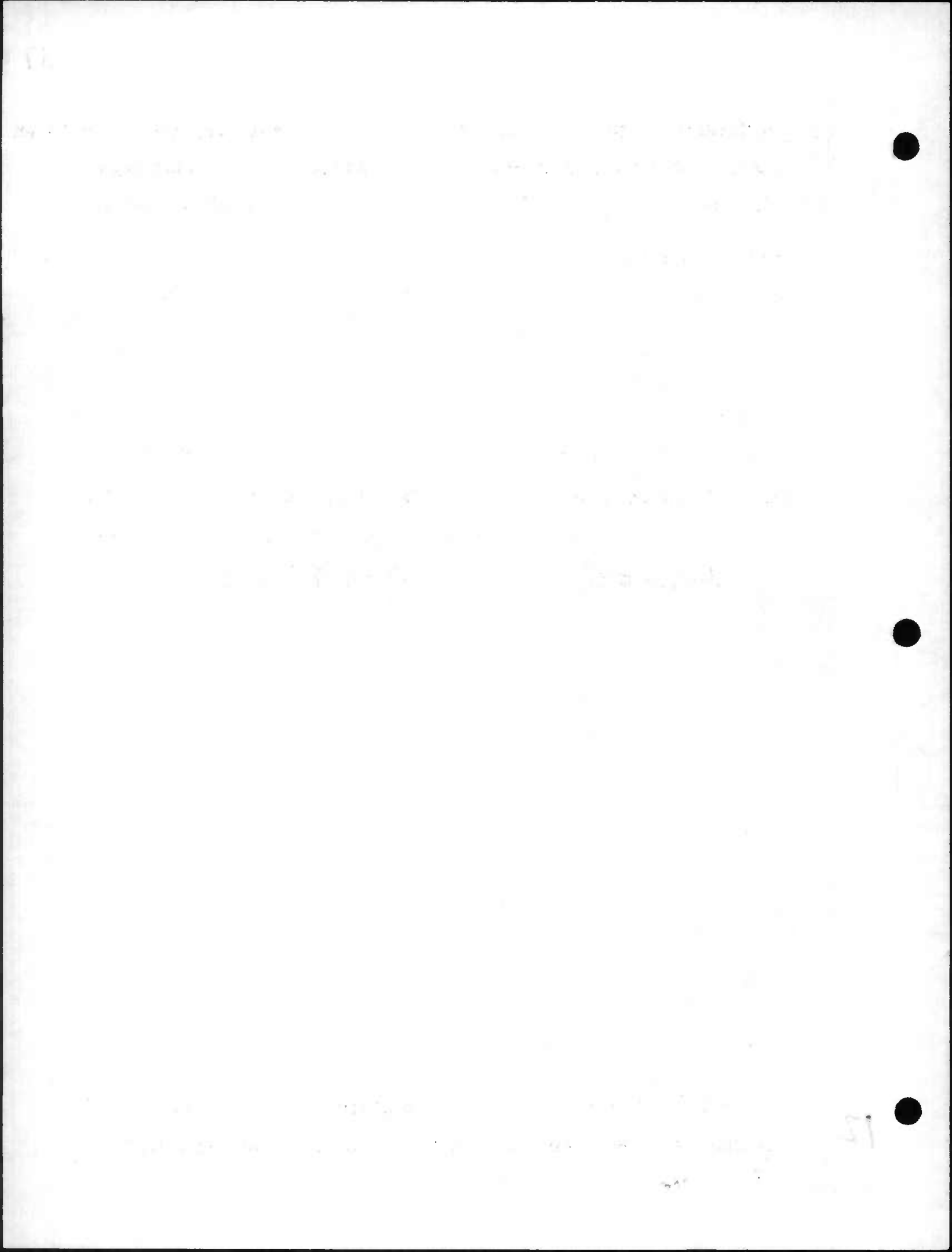
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 58760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



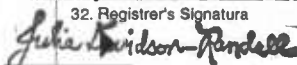




**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14858

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>HENRY WILSON GLACE JR.</b>						2. Date of Death Month Day Year <b>MAY 19 1996</b>		3. Time of Death <b>1:30 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>TOWSON, MD.</b>		4c. County of Death <b>BALTIMORE</b>		
<b>Funeral Director</b>	5. Social Security Number <b>214-03-3870</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth <b>July 27, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>800 Southerly Rd.</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+) <b>3</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENGINEER</b>			16b. Kind of Business/Industry <b>INDUSTRIAL</b>				
17. Father's Name (First, Middle, Last) <b>HENRY GLACE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH BOOKER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>DELMA GLACE Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>800 Southerly Rd. Apt. 702 Balto. Md. 21286</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gdn.</b>		Date <b>5/22/96</b>		20c. Location - City or Town, State <b>Timonium, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212</b>							
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>UROSEPSIS</b> Due to (or as a consequence of):</p> <p>b. <b>DEEP VENOUS THROMBOSIS</b> Due to (or as a consequence of):</p> <p>c. <b>LYMPHOMA</b> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 10%; text-align: center;"> <p><b>16 DAYS</b></p> <p><b>3 WEEKS</b></p> <p><b>3 WEEKS</b></p> </div> </div>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>CORONARY ARTERY DISEASE</b>  <b>DIABETES MELLITUS</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number <b>D41410</b>		29d. Date signed (Month, Day, Year) <b>May 19th, 96.</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOGINDER P. MEHTA, M.D. ST. JOSEPH MEDICAL CENTER TOWSON, MD.</b>											
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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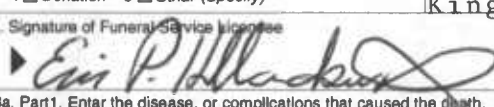
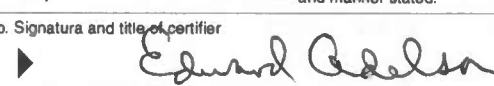
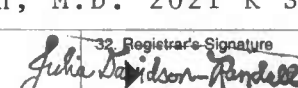
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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14859

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>William Goldberg</b>					2. Date of Death Month Day Year <b>May 8, 1996</b>			3. Time of Death <b>12:15pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>2208 Ross Rd.</b>					4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>		
<b>Funeral Director</b>	5. Social Security Number <b>286-14-9028</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 21, 1915</b>		9. Birthplace (State or Foreign Country) <b>Lithuania</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2208 Ross Road</b>					10f. Zip Code <b>20910</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business/Industry <b>Meat Distribution</b>			
17. Father's Name (First, Middle, Last) <b>Phillip Goldberg</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Goldberg</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Judith Mopsik</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6415 79th St., Cabin John, Md. 20818</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Mem. Grdn.</b>		Date <b>5/12/96</b>		20c. Location - City or Town, State <b>Falls Church, Va</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Ives-Pearson Funeral Homes Falls Church, Va 22046</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cancer of the prostate</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate interval Between Onset and Death <b>1 year</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number <b>D00059</b>			29d. Date signed (Month, Day, Year) <b>5/13/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Edward Adelson, M.D. 2021 K Street, N.W., Wash., DC</b>											
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>					32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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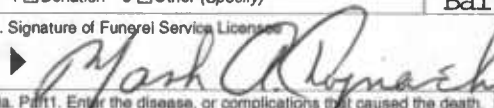
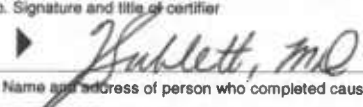
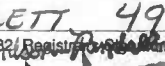
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

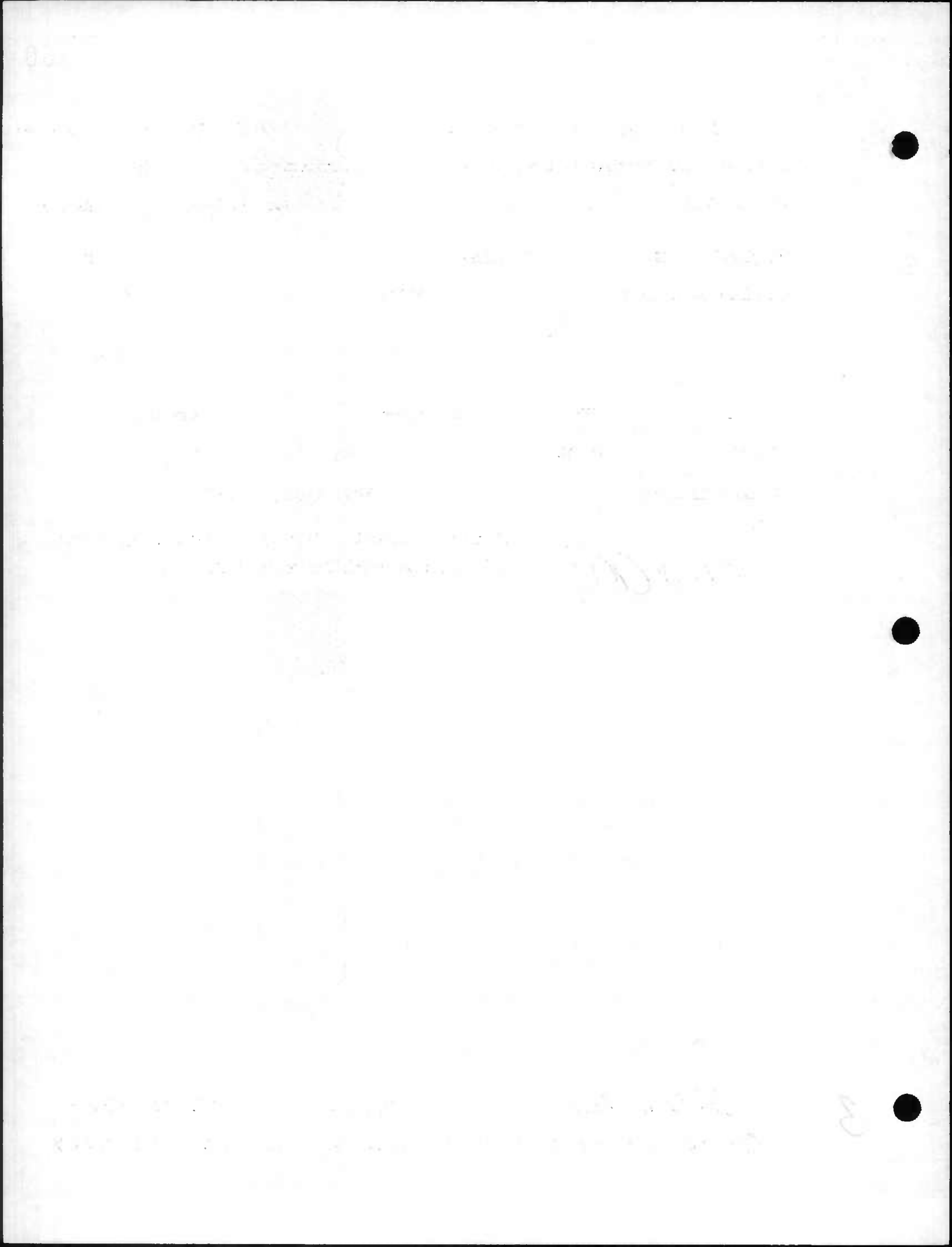
96 14860

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN L. GIBBS</b>				2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>11:22 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>212-22-2734</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F <b>X</b>	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 30 1928</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>X</b>	
	10e. Street and Number <b>Steelton Ave. 1227</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>NA</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Henry Ernest</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amy Davis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Linda Wilkinson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Walnut Ave. 1807 Balt., MD. 21222</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National</b>		Date <b>May 20</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balt., MD. 21224</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of): <b>Pneumonia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 days</b> <b>2 weeks</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Squamous Cell Lung Cancer</b> <b>Coronary Artery Disease</b> <b>Diabetes mellitus</b>								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>M6156</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. TONI D. SUBLETT 4940 EASTERN AVE BALTIMORE, MD 21224</b>									
31. Date filed (Month, Day, Year) <b>21 1996</b>									
32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 item #26, filmg, 735, 5/31/96, cyw, per doc  
 Certificate of Death

96 14861

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charlotte C Horton</b>						2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>10:16A</b>						
	4a. Facility Name (If not institution, give street and number) <b>1617 LORIMER Rd</b>						4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>						
Funeral Director	5. Social Security Number <b>217 28 1944</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 14 1933</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>A.A. Co.</b>		10c. City, Town or Location <b>Glen Burnie</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number <b>1617 LORIMER Rd</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aerospace Tech</b>			16b. Kind of Business/Industry <b>Westinghouse</b>							
	17. Father's Name (First, Middle, Last) <b>Charles Pease</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Agnes Gallery</b>								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Cheryl Harrison Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17300 OLDE Frederick Rd MT AIRY MD 21771</b>								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		Data <b>5-17-96</b>		20c. Location - City or Town, State <b>Balt, MD</b>								
	21. Signature of Funeral Service Licensee <b>Thomas J. Shand Jr</b>				22. Name and Address of Facility <b>Raymond C. Fink Funeral Home 436 Crain Hwy SW Glen Burnie MD 21061</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Asthma</b> Due to (or as a consequence of): b. <b>High Blood Pressure</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>Neil E. Redgett MD</b>		29c. License number <b>D 33296</b>		29d. Date signed (Month, Day, Year) <b>5-17-96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7711 Quarterfield Rd Glen Burnie MD 21061</b>															
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature <b>Susan Davidson-Randall</b>											

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14862

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ZOLA WASHINGTON HODGES Jr.

2. Date of Death

Month Day Year  
May 13 1996

3. Time of Death

04:37 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220 14 5361

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 5, 1922

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4923 Brookwood Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Thrie's Potato Chips

17. Father's Name (First, Middle, Last)

Zola Washington Hodges Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hester (unknown)

19a. Informant's Name/Relationship (Type, Print)

Ethel Hodges

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4923 Brookwood Road Baltimore, Maryland 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn Cemetery

Date

5/16/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE Pulmonary DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Eleven years

Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AS2441614/12

29d. Date signed (Month, Day, Year)

May, 13, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WEN-MIN CHUU, 3001 S. Hanover Street., Baltimore, MD. 21225

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14863

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE HODGSON</b>				2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>10:22 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOUR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215 01 0802</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 20, 1920</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4021 Belle Grove Road</b>				10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Packaging Company</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Slater</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie Haynes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>George Hodgson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1142 Wharf Drive Pasadena, Maryland 21122</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>5/18/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Jerome Francoulli</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ACUTE CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): b. <b>PAROXYSMAL ATRIAL FIBRILLATION</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>18 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASPIRATION PNEUMONIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Maya Thomas PGY-I</i>						
		29c. License number <b>2441614-32</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MAYA THOMAS</b>		31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>						
		32. Registrar's Signature <i>Julia Anderson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14864

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE W. HARE Sr.</b>					2. Date of Death Month Day Year <b>MAY 17 1996</b>		3. Time of Death <b>11:55 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>					4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>213-03-8247</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 10, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Balto. City</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1117 Roland Heights Ave.</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Transportation Dignan Industries</b>			
17. Father's Name (First, Middle, Last) <b>Clarence Hare</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Belt</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gary Hare</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1117 Roland Heights Ave. Balto., MD 21211</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Pk</b>			Date <b>5/20/96</b>		20c. Location - City or Town, State <b>Eldersburg, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Burgess-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Congestive heart failure</b> Due to (or as a consequence of): b. <b>Ischemic heart disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate interval Between Onset and Death <b>2 years</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 			29c. License number <b>015561</b>			29d. Date signed (Month, Day, Year) <b>5/17/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. H. Henss to Burgee-Henss Funeral Home, 7401 Oriskany in Falls, Md 20747</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14865

Reg. No.

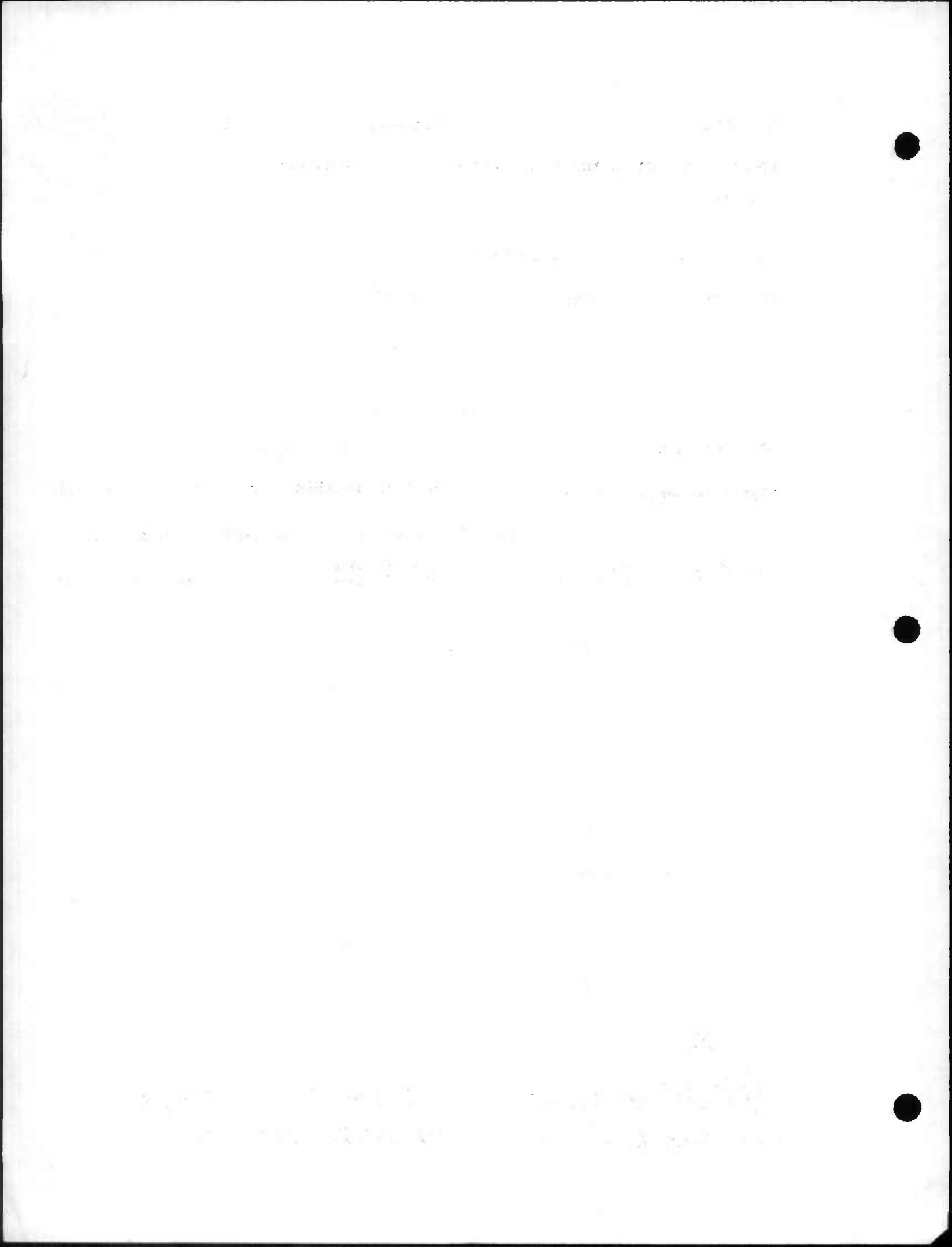
<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Alexander Henderson</b>				2. Date of Death Month <b>5</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>10:58AM</b>													
	4a. Facility Name (If not institution, give street and number) <b>Greenspring Nursing and Rehab. Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>													
<b>Funeral Director</b>	5. Social Security Number <b>249-40-5944</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT 30 1927</b>													
	9. Birthplace (State or Foreign Country) <b>S.C.</b>																			
Usual Residence of Decedent																				
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
10e. Street and Number <b>4207 Park Heights Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U S A</b>														
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Box Stripper</b>			16b. Kind of Business/Industry <b>Paper Box Co.</b>													
17. Father's Name (First, Middle, Last) <b>Alex Henderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Able</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Rosetta Henderson Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4207 Park Heights Avenue Baltimore, Md 21215</b>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>5-21-96</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>														
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>																
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%;">a. <b>ACUTE CEREBROVASCULAR ACCIDENT</b></td> <td style="width:20%;">Approximate Interval Between Onset and Death <b>ACUTE</b></td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 4em;">{</td> <td>b. <b>HYPERTENSIVE CEREBROVASCULAR DISEASE</b></td> <td><b>YEARS</b></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> <tr> <td colspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. <b>ACUTE CEREBROVASCULAR ACCIDENT</b>	Approximate Interval Between Onset and Death <b>ACUTE</b>	{	b. <b>HYPERTENSIVE CEREBROVASCULAR DISEASE</b>	<b>YEARS</b>	c. _____		d. _____		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
Immediate Cause (Final disease or condition resulting in death)	a. <b>ACUTE CEREBROVASCULAR ACCIDENT</b>	Approximate Interval Between Onset and Death <b>ACUTE</b>																		
{	b. <b>HYPERTENSIVE CEREBROVASCULAR DISEASE</b>	<b>YEARS</b>																		
	c. _____																			
	d. _____																			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																				
<b>DIABETES MELLITUS</b>  <b>CONGESTIVE CARDIOMYOPATHY</b>																				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>																		
		29c. License number <b>D-19425</b>			29d. Date signed (Month, Day, Year) <b>5/17/96</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4615 PARK HEIGHTS AVE. BALTIMORE, MD. 21215</b>																				
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>[Signature]</i>																		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



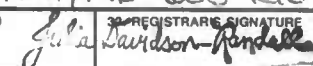




96 14866

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM HOWELLS</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>18</b> YEAR <b>96</b>		3. TIME OF DEATH <b>2345</b> M					
4. SOCIAL SECURITY NUMBER <b>578-40-3734</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-09-12</b>					
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS MD</b>					
9c. COUNTY OF DEATH <b>ANNE ARUNDEL CO.</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>					
10c. CITY, TOWN OR LOCATION <b>Davidsonville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3495 Vicksburg Drive</b>					
10f. ZIP CODE <b>21035</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cost Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government Agency</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Lewis Howells</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Jane Morgan</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Virginia Howells</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3495 Vicksburg Drive, Davidsonville, MD</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		20c. LOCATION — City or Town, State <b>5/22 Davidsonville, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>12 Ridgely Ave. Annapolis, MD 21401 Hardesty Funeral Home, P.A.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Heart disease</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>b. <b>CVA x 5</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>c. <b>PULmonary embolisms</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> </table>								b. <b>CVA x 5</b>	DUE TO (OR AS A CONSEQUENCE OF):	c. <b>PULmonary embolisms</b>	DUE TO (OR AS A CONSEQUENCE OF):
b. <b>CVA x 5</b>	DUE TO (OR AS A CONSEQUENCE OF):										
c. <b>PULmonary embolisms</b>	DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO					
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D38526</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/19/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LISA MURRAY, MD 600 Ridgely Ave S120 ANNAPOLIS MD 21401</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 21 1996</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARY L. HELMHOLZ</b> <del>MARY HELMHOLTZ</del>					2. Date of Death Month <b>MAY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>1830</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>					4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>219-32-6219</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 18, 1930</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>237 Walgrove Road</b>					10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cafeteria Work</b>			16b. Kind of Business/Industry <b>Public Schools</b>		
17. Father's Name (First, Middle, Last) <b>James Smith</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen McDonald</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lori A. Helmholtz/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1282 Battery Ave. Baltimore, Md. 21230</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		Date <b>5-22-96</b>		20c. Location - City or Town, State <b>Owings Mills, Md.</b>		
21. Signature of Funeral Service Licensee <b>C. Brian Powell</b>					22. Name and Address of Facility <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS WITH MULTI ORGAN FAILURE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>C. Ravi MD</b>					29c. License number <b>D37333</b>		29d. Date signed (Month, Day, Year) <b>MAY 19, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. RAVI MD NHC, BALTO MD 21133</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature <b>John Andrew Randall</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

15

**State  
Registrar**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14868

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARENCE BIDDLE HANSON				2. Date of Death Month Day Year MAY 15 1996				3. Time of Death 10:40 P.M.			
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 216-05-6685		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 4, 1906		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 3022 St. Paul Street				10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Post Office				
	17. Father's Name (First, Middle, Last) Charles Biddle Hanson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Estelle Collins							
	19a. Informant's Name/Relationship (Type, Print) Mrs. William J. Meyers (friend)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Ln. HR 601 Catonsville, MD 21228							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date May 18		20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee <i>Thomas Joseph Boer</i>				22. Name and Address of Facility Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Cerebral infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5-9-96	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CARCINOMA of COLON.</i> <i>CARCINOMA of PROSTATE.</i>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>A.H. Ghiladi, M.D.</i>				29c. License number D-12849		29d. Date signed (Month, Day, Year) 5-16-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.H. GHILADI, M.D. 7600 OSLER DR. TOWSON MD 21204												
31. Date filed (Month, Day, Year) MAY 21 1996		32. Registrar's Signature <i>John Davidson-Randall</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21260-0760

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14869

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lee R. Hoffman

2. Date of Death  
Month Day Year

May 7 1996

3. Time of Death

5:10AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4701 Willard Ave. #1124

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

220 64 9971

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Feb 11 1907

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Florida

10b. County

Broward

10c. City, Town or Location

Coconut Creek

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2614 Nassau Bend

10f. Zip Code

33066

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maurice Rabenobets

18. Mother's Name (First, Middle, Maiden Surname)

Eva Abramson

19a. Informant's Name/Relationship (Type, Print)

Harold Hoffman, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2614 Nassau Bend, Coconut Creek, Florida 33066

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Mem Gdns

Data

5/8

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes  
Falls Church, Va 2204623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ENTERO-CUTANEOUS FISTULA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 02210

29d. Date signed (Month, Day, Year)

5-7-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRWIN H. ADAM, M.D. - 5454 WISCONSIN AVE, CHEVY CHASE, MD. - 20817

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

MD. - 20817

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14870

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIE WILLIAM JONES, JR.</b>				2. Date of Death Month <b>May</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>8:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>612 McKewin Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-40-3443</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 13, 1944</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>612 McKewin Avenue</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Bus Driver</b>		16b. Kind of Business/Industry <b>Baltimore County Public Schools</b>		
17. Father's Name (First, Middle, Last) <b>Willie W. Jones, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Brooks</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Florene D. Jones</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 McKewin Avenue, Baltimore, MD 21218</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		Data <b>5-24</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>March Funeral Home</b> <b>1101 E. North Avenue, Balto., MD 21202</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Lung Cancer</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>6 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				29c. License number <b>D46118</b>		29d. Date signed (Month, Day, Year) <b>May 21, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sahet COOPER MD 3333 N. CALVERT ST Suite 107 BALTO MD 21218</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14871

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedant's Name (First, Middle, Last) <u>Lillie Jones</u>				2. Date of Death Month <u>May</u> Day <u>18</u> Year <u>1996</u>		3. Time of Death <u>07:53 am</u>	
	4e. Facility Name (If not institution, give street and number) <u>Mercy Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>NA</u>	
<b>Funeral Director</b>	5. Social Security Number <u>217-20-8805</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>79</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>July 12, 1916</u>	
	9. Birthplace (State or Foreign Country) <u>MD</u>							
Usual Residence of Decedant								
10a. State <u>MD</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>4728 York Road</u>				10f. Zip Code <u>21212</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th</u> College (1-4 or 5+) <u>NA</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laborer</u>			16b. Kind of Business/Industry <u>Mercy Hospital</u>	
17. Father's Name (First, Middle, Last) <u>LENNELL JONES</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>RACHAEL BUTLER</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Doris Williams - Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4728 York Rd. Apt. A Balto Md. 21212</u>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GARRISON FOREST VETERAN</u>		Date <u>5-22-96</u>		20c. Location - City or Town, State <u>Owings Mills, MD</u>
21. Signature of Funeral Service Licensee <u>Phyllis B. Harris</u>				22. Name and Address of Facility <u>MARCH FIDELITY HOME - EAST 1101 E. NORTH AVE. BALTO MD 21202</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Metastatic Uterine Cancer</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>9 months</u></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary artery disease</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>[Signature] MD PhD</u>				29c. License number <u>AM-2552001-1061</u>		29d. Date signed (Month, Day, Year) <u>May 18, 1996</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Beth Brannon Hopewell 301 S Paul Place Baltimore MD</u>								
31. Date (Month, Day, Year) <u>MAY 21 1996</u>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14872

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD FRANK JARZYNSKI</b>				2. Date of Death Month <b>MAY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>4:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215 09 6022</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 17, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7713 Warsaw Avenue</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W. II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>State Roads Comm.</b>		
17. Father's Name (First, Middle, Last) <b>Frank P. Jarzynski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Szczesniak</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Doris Balsarick</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6915 Harewood Park Drive Baltimore, Maryland 21220</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		Date <b>5/22/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Jerome Znamionowski</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Squamous cell carcinoma of lung</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive lung disease</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Paul Gormley MD</i>				29c. License number <b>D18587</b>		29d. Date signed (Month, Day, Year) <b>MAY 19 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL GORMLEY 980 CATON AVE BALTO MD 21229</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14873

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary T. Jacobs</b>				2. Date of Death Month Day Year <b>May 18 1996</b>		3. Time of Death <b>12:29 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Meridian Nursing Home - Hammonds Lane</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218 44 3325</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 3, 1908</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent								
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
10e. Street and Number <b>Meridian Nursing Home</b> <b>613 Hammonds Lane</b>								
10f. Zip Code <b>21225</b>								
10g. Citizen of What Country? <b>U.S.</b>								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced								
12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:								
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)								
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>								
16b. Kind of Business/Industry <b>Own Home</b>								
17. Father's Name (First, Middle, Last) <b>William Hodges</b>								
18. Mother's Name (First, Middle, Maiden Surname) <b>Milcah Ashley</b>								
19a. Informant's Name/Relationship (Type, Print) <b>William Jacobs</b>								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>326 W. Riverview Road Baltimore, Maryland 21225</b>								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)								
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>								
20c. Location - City or Town, State <b>Baltimore, Maryland</b>								
21. Signature of Funeral Service Licensee <i>Jerome Zimmerman</i>								
22. Name and Address of Facility <b>Gonce Funeral Home P.A.</b> <b>4001 Ritchie Highway Baltimore, Md. 21225</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Insufficiency</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>2 Dgs. / 1 wk.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease</b> <b>HASDID</b>								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier <i>Alan L. ...</i>								
29c. License number <b>D30555</b>								
29d. Date signed (Month, Day, Year) <b>5/20/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>707 E. Fort Ave Balto Md.</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>								
32. Registrar's Signature <i>John ...</i>								

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings and their implications for the field of research.

4. The fourth part of the report is a conclusion and a discussion of the limitations of the study. It also includes a list of references and a list of appendices.

5. The fifth part of the report is a summary of the main findings of the study. It includes a discussion of the implications of the results and a list of recommendations for further research.

6. The sixth part of the report is a list of references. It includes a list of books, articles, and other sources used in the study.

7. The seventh part of the report is a list of appendices. It includes a list of tables, figures, and other supplementary material.

8. The eighth part of the report is a list of references. It includes a list of books, articles, and other sources used in the study.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14874

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS B. KRAUSE				2. Date of Death Month Day Year MAY 18 1996		3. Time of Death 4:35 AM	
	4a. Facility Name (If not institution, give street and number) 3601 CLARKS LANE, APT. 314				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-09-4109		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 11, 1909	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3601 CLARKS LANE, APT. 314				10f. Zip Code 21215		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANUFACTURER		16b. Kind of Business/Industry NURSES UNIFORMS		
17. Father's Name (First, Middle, Last) ISRAEL KRAUSE				18. Mother's Name (First, Middle, Maiden Surname) DORA AFRIMOFF				
19a. Informant's Name/Relationship (Type, Print) JEAN KRAUSE (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 CLARKS LA., APT. 314 BALTO., MD 21215				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BETH EL MEM. PARK		20c. Location - City or Town, State RANDALLSTOWN, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Renal failure and dehydration</i> Due to (or as a consequence of): b. <i>Cancer of the prostate</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>10 days</i> <i>17 yrs</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>severe congestive heart failure</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Stanley M. Rosen MD</i>				29c. License number D09775		29d. Date signed (Month, Day, Year) 5/18/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STANLEY M. ROSEN MD, 2435 W. Belvidere Ave., Balto, MD, 21215								
31. Date Recd (Month, Day, Year) MAY 21 1996				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

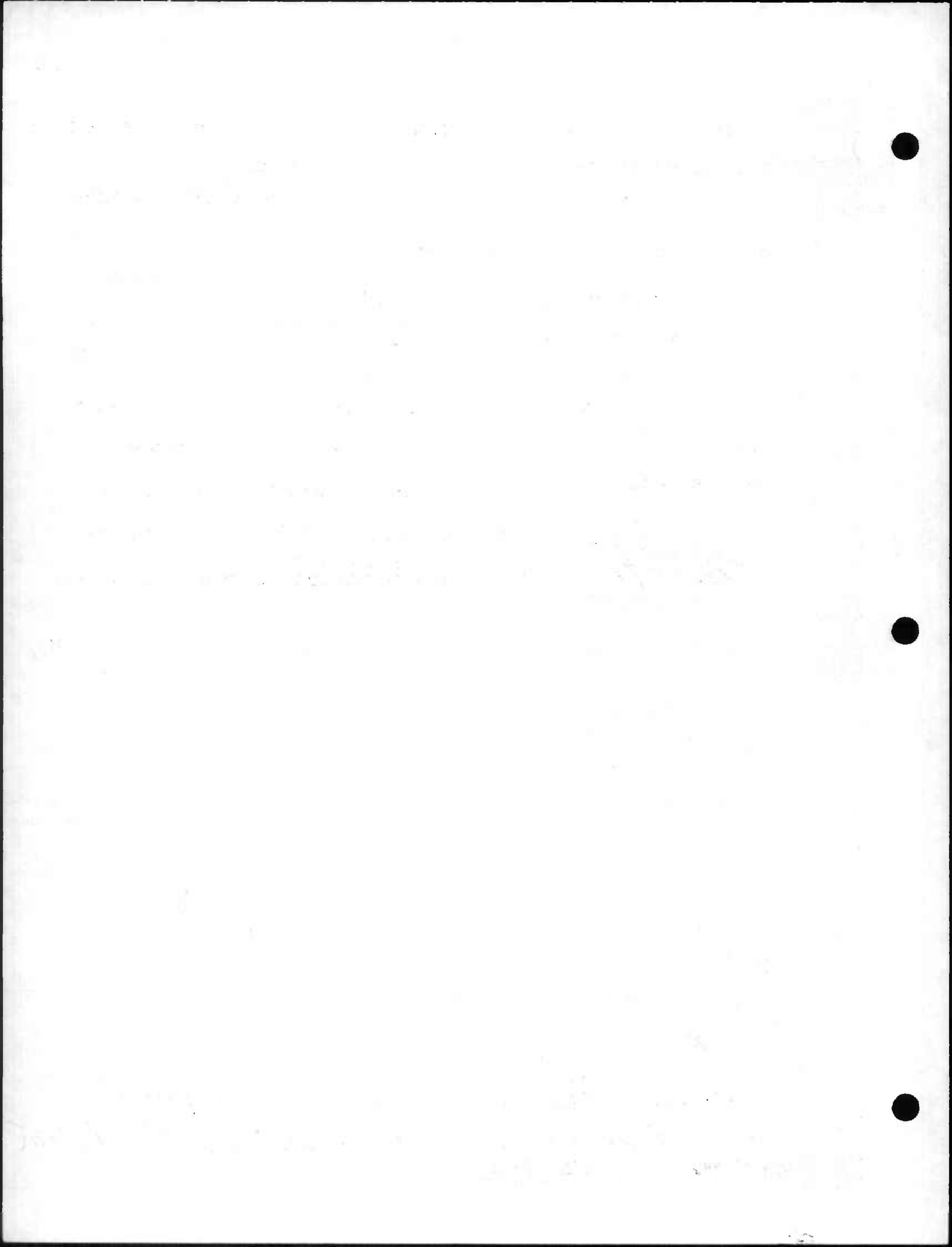
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



5/21/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ida Lipschutz</b>				2. Date of Death Month <b>May</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>2:20 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Jewish Convalescent Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>177-28-4153D</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 3, 1902</b>	9. Birthplace (State or Foreign Country) <b>Lithuania</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3601 Fords Lane</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Julius Rhodes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah (Unknown)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Shirley Weisman (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Bucksway Road Owings Mills, MD 21117</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Lebanon</b>		20c. Location - City or Town, State <b>05/16/96 Glenolden, Del Co., PA</b>		20d. Date	
	21. Signature of Funeral Service Licensee <i>Jay Alay Levine</i>		22. Name and Address of Facility <b>Sol Levinson &amp; Bros., Inc.</b> <b>8900 Reisterstown Road Baltimore, MD 21208</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>b. Cardiovascular Insufficiency</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Kenneth L. Glick</i>		29c. License number <b>D23679</b>		29d. Date signed (Month, Day, Year) <b>05-15-96</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kenneth L. Glick MD 20 Crossroads Dr Suite 12 Owings Mills MD 21117</b>							
	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>John D. ...</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 14876

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES DANIEL				2. DATE OF DEATH MAY 16, 1996				3. TIME OF DEATH 10:34 p.m.	
4. SOCIAL SECURITY NUMBER 217-20-2728		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 2, 1927		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH ANNE ARUNDEL CO	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7332 GREEN ACRES DRIVE				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 <sup>th</sup> College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BRICK MAKER			16b. KIND OF BUSINESS/INDUSTRY GENERAL REFRACTORY		
17. FATHER'S NAME (First, Middle, Last) FRANK LEVRONE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAUDE WILLET					
19a. INFORMANT'S NAME (Type/Print) EVE LEVRONE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7332 GREEN ACRES DRIVE, GLEN BURNIE, MD					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK		DATE 5-22		20c. LOCATION — City or Town, State RANDALLSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William C. March</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>with permythemia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetic Mellitus Type II</i>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. A. E. Subong Jr.</i>				29c. LICENSE NUMBER D02583		29d. DATE SIGNED (Month, Day, Year) 5/20/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR A E SUBONG JR 206 CRAIN HWY GLEN BURNIE MD									
31. DATE FILED (Month, Day, Year) MAY 21 1996		32. FILED IN <i>John Davidson - Registrar</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14877

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Daniel Leidner Sr.				2. DATE OF DEATH MONTH DAY YEAR May 14 1996		3. TIME OF DEATH 7:30 P. M.	
4. SOCIAL SECURITY NUMBER 216 12 5269		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 3, 1922	
9a. FACILITY NAME (If not institution, give street and number) 7622 Marcy Drive				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7622 Marcy Drive				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber		16b. KIND OF BUSINESS/INDUSTRY Self Employed			
17. FATHER'S NAME (First, Middle, Last) Daniel M. Leidner				16. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Bojik			
19a. INFORMANT'S NAME (Type/Print) Richard Leidner Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7622 Marcy Drive Glen Burnie, Maryland 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		DATE 5/17		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles Leone</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASCVD</i>							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerry Buggs MD</i>		29c. LICENSE NUMBER D28640		29d. DATE SIGNED (Month, Day, Year) 5/15/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5240 Duke St. Apt 206 Alexandria, VA 22304							
31. DATE FILED (Month, Day, Year) MAY 21 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





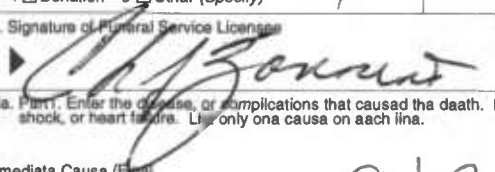
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14878

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Philip R. LaPietra</b>				2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>9:40 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>150-05-4443</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-20-1908</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
Usual Residence of Decedent								
10a. State <b>Md.</b>			10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Annapolis</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>1010 Tallwood Road</b>			10f. Zip Code <b>21403</b>		
10g. Citizen of What Country? <b>U.S.A.</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>N.A.</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security</b>			16b. Kind of Business/Industry <b>Lever Brothers</b>			17. Father's Name (First, Middle, Last) <b>Salvatore LaPietra</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Crispi</b>			19a. Informant's Name/Relationship (Type, Print) <b>Mary G. LaPietra</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1010 Tallwood Road Apt. 2 C. Annapolis, Md. 21403</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Wash. Mem. Park 5-20 Paramus, New Jersey</b>			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis, Md. 21401</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CVA</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAD SIP MI</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) <b>M</b>								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License number <b>D23557</b>								
29d. Date signed (Month, Day, Year) <b>5-17-96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anthony Caputo M.D. 139 Old Solomons Island Road. Annapolis, MD 21401</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerPhysician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14879

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT MANEKIN

2. Date of Death

MAY 17 1996

3. Time of Death

6:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

216-09-3785

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 14, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 SLADE AVE., APT. 206

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

RETAIL CREDIT MANAGER

16b. Kind of Business/Industry

RELIABLE STORES

17. Father's Name (First, Middle, Last)

SAMUEL

MANEKIN

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE

BLOOM

19a. Informant's Name/Relationship (Type, Print)

MR. STEVEN MANEKIN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3503 ARBORWOOD CT. BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON (CHIZUK AMUNO)

Date

5/20/96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

YEARS

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

YEARS

d. ABDOMINAL AORTIC ANEURYSM

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K.S. RAO, M.D.

29c. License number

D43462

29d. Date signed (Month, Day, Year)

MAY 17 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. RAO, M.D., NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD

31. Date filed (Month, Day, Year)

MAY 21 1996

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14880

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Howard E. Marshall Sr.</b>				2. Date of Death Month <b>May</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>6:45 Am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Liberty medical center</b>				4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>226-28-0171</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 4, 1924</b>	9. Birthplace (State or Foreign Country) <b>VA.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Balto</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3802 Sequoia Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>3yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>				16b. Kind of Business/Industry <b>McCormick spice co</b>	
	17. Father's Name (First, Middle, Last) <b>Fred Marshall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Iola Jones</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy A. Marshall - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3802 Sequoia Ave Balto, md 21215</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Data <b>5/20/96</b>	20c. Location - City or Town, State <b>Glen Burnie, md</b>		
	21. Signature of Funeral Service Licensee <b>John March</b>				22. Name and Address of Facility <b>March F. H. West 4300 Wabash Ave</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiorespiratory arrest</b> Due to (or as a consequence of): <b>b. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b> <b>years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cancer of the Prostate</b> <b>Cervical Nerve Plexus Anomaly</b> <b>Nerflux Eriophytia</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John March</b>		29c. License number <b>022031</b>		29d. Date signed (Month, Day, Year) <b>5-15-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Larry Steven Perry Jr. 2116 Maryland Ave Balto md 21218</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

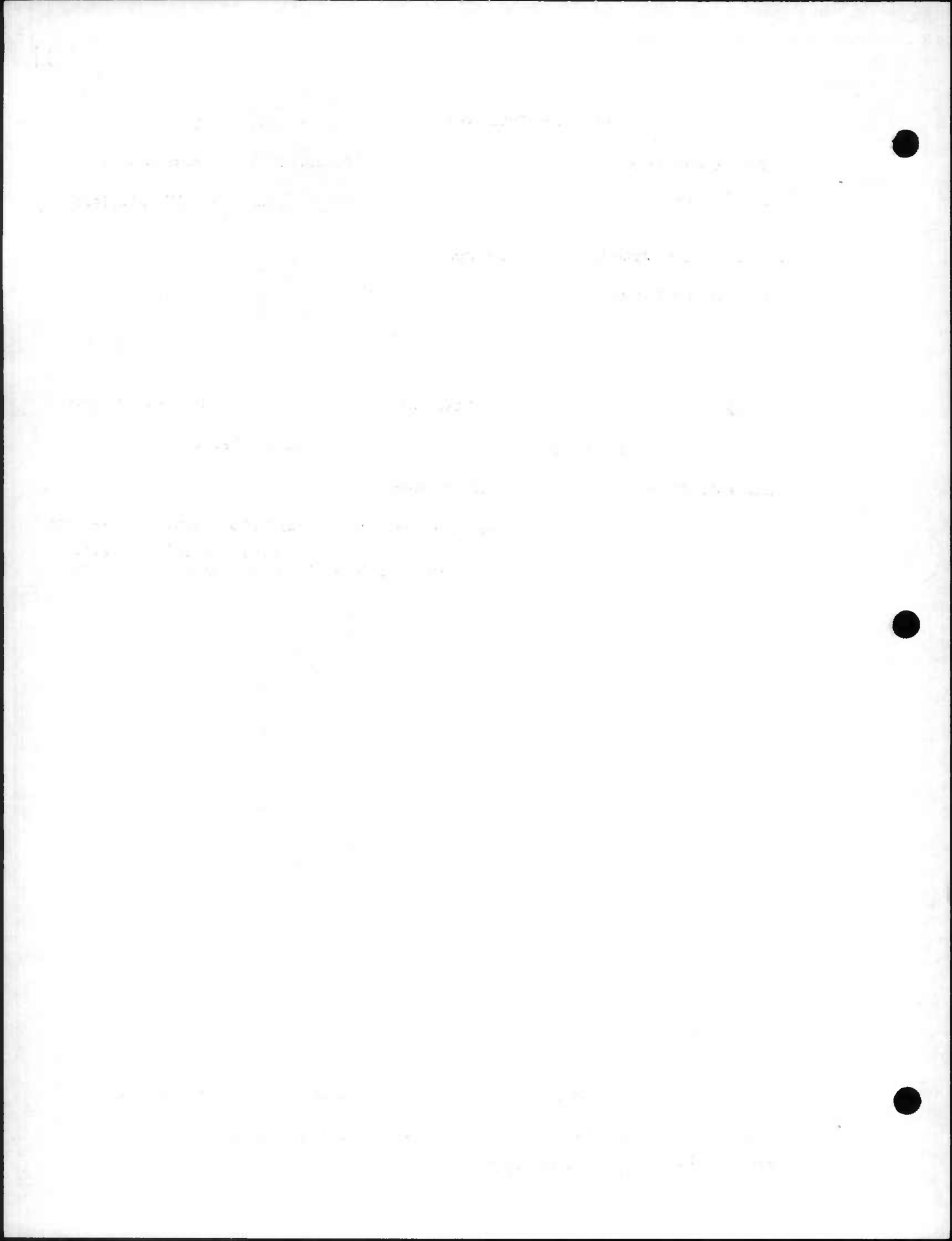
Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14881

**Division of Vital Records, P.O. Box 68760,**





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14882

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Nancy Miller</i>				2. Date of Death Month <i>May</i> Day <i>14</i> Year <i>1996</i>		3. Time of Death <i>10:35 pm</i>											
	4a. Facility Name (If not institution, give street and number) <i>Harbor Hospital Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>											
<b>Funeral Director</b>	5. Social Security Number <i>212 12 2229</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>83</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>July 11, 1912</i>											
							9. Birthplace (State or Foreign Country) <i>Alabama</i>											
Usual Residence of Decedent																		
10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <i>2719 Norfen Road</i>				10f. Zip Code <i>21227</i>		10g. Citizen of What Country? <i>U.S.</i>												
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>											
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Home Maker</i>		16b. Kind of Business/Industry <i>In own home</i>												
17. Father's Name (First, Middle, Last) <i>Arch Brady Halpin</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Beulah Lee Craft</i>														
19a. Informant's Name/Relationship (Type, Print) <i>Herbert J. Miller</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2719 Norfen Road Baltimore, Maryland 21227</i>														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lakeview Memorial Park</i>		Date <i>5/18/96</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>											
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</i>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%;">a. <i>Sepsis Unknown Source</i> Due to (or as a consequence of):</td> <td style="width:20%;">Approximate Interval Between Onset and Death <i>24hr</i></td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td>b. <i>Myocardial Infarction</i> Due to (or as a consequence of):</td> <td><i>24hr</i></td> </tr> <tr> <td>c. <i>Acute Respiratory Distress Syndrome</i> Due to (or as a consequence of):</td> <td><i>24hr</i></td> </tr> <tr> <td>d. <i>Acute Renal Failure</i></td> <td><i>24hr</i></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. <i>Sepsis Unknown Source</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>24hr</i>	{	b. <i>Myocardial Infarction</i> Due to (or as a consequence of):	<i>24hr</i>	c. <i>Acute Respiratory Distress Syndrome</i> Due to (or as a consequence of):	<i>24hr</i>	d. <i>Acute Renal Failure</i>	<i>24hr</i>
Immediate Cause (Final disease or condition resulting in death)	a. <i>Sepsis Unknown Source</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>24hr</i>																
{	b. <i>Myocardial Infarction</i> Due to (or as a consequence of):	<i>24hr</i>																
	c. <i>Acute Respiratory Distress Syndrome</i> Due to (or as a consequence of):	<i>24hr</i>																
	d. <i>Acute Renal Failure</i>	<i>24hr</i>																
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial Fibrillation, Alzheimer's</i>  <i>Breast Cancer</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
			28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature] medical intern</i>		29c. License number <i>AS2441614-30</i>		29d. Date signed (Month, Day, Year) <i>May 14 1996</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Lawrence Jack Fogelson</i>			<i>Harbor Hospital Center 3001 South Hanover St Baltimore, Maryland 21225</i>															
31. Date filed (Month, Day, Year) <i>MAY 21 1996</i>			32. Registrar's Signature <i>[Signature]</i>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14883

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Waldo Moore

2. Date of Death

Month

Day

Year

5

19

96

3. Time of Death

5:30 pm.

4a. Facility Name (If not institution, give street and number)

303 Allendale Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Maryland

Funeral  
Director

5. Social Security Number

215-12-1630

6. Sex

M

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10-23-13

9. Birthplace (State or Foreign Country)

USA NC

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes No

10e. Street and Number

303 Allendale Street

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

6th

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Maritime

17. Father's Name (First, Middle, Last)

Hardy Moore

18. Mother's Name (First, Middle, Maiden Surname)

Sallie B. Whitaker

19a. Informant's Name/Relationship (Type, Print)

Ethel Moore / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Allendale Street Balto, Md 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem Pk

Date

5/24/96 Balto, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James Morton &amp; Sons 1701 Laurens St

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Squamous Cell Carcinoma of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George Taler, M.D.

29c. License number

D19858

29d. Date signed (Month, Day, Year)

5/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Taler, M.D. 29 S. Taca St. Baltimore, Md. 21201

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

Gina Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 14884

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Leonard Miller</b>				2. Date of Death Month <b>May</b> Day <b>14</b> Year <b>1996</b>		3. Time of Death <b>9:38 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>212-22-0849</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 24, 1930</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>215 Plymouth Ln.</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1947-1968</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Correctional Officer</b>		16b. Kind of Business/Industry <b>Prison system</b>				
	17. Father's Name (First, Middle, Last) <b>Lawrence Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Naomi Jones</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Ruby Miller</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>215 Plymouth Ln. Glen Burnie, MD 21061</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Zoar Cem.</b>		20c. Location - City or Town, State <b>5-18-96 Conowingo, MD</b>					
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Beard Funeral Home 552 Lewis St. Havre de Grace, MD 21078</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  e. <i>Pulmonary edema</i> Due to (or as a consequence of): b. <i>Coronary heart failure</i> Due to (or as a consequence of): c. <i>ASVD</i> Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ben W. Jerome MD</i>		29c. License number <b>d34914</b>		29d. Date signed (Month, Day, Year) <b>5/16/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALEXANDER JEROME, M.D. 8028 RITCHIE HWY, GLEN BURNIE, MARYLAND 21061</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14885

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <i>Dorothy Murphy</i>						2. Date of Death Month <i>5</i> - Day <i>18</i> - Year <i>1996</i>		3. Time of Death <i>5:30 p.m.</i>	
	4a. Facility Name (If not institution, give street and number) <i>2911 PARKWOOD AVE.</i>						4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>218-28-1701</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>3-9-1929</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>2911 PARKWOOD AVE</i>				10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <i>Negro</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>CAJETERIA WKR</i>			16b. Kind of Business/Industry <i>BALTO. CITY</i>		
	17. Father's Name (First, Middle, Last) <i>John King</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Marie Chase</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Denise Edwards</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1817 Ruxton Ave. BALTO. MD. 21216</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GARRISON FOREST CEM</i>		20c. Location - City or Town, State <i>5/24 Owings Mills MD</i>					
	21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>				22. Name and Address of Facility <i>Joseph L. Russ FUNERAL HOME 2222 W. North Ave. BALTO. MD. 21216</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Hepatocellular Carcinoma</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Approximate Interval Between Onset and Death <i>6 months</i>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Stephen L. Lin</i>				29c. License number <i>P09748</i>		29d. Date signed (Month, Day, Year) <i>5/20/96</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Stephen L. Lin, MD 22 S. Greene St. Baltimore, MD 21201</i>										
31. Date filed (Month, Day, Year) <i>MAY 21 1996</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





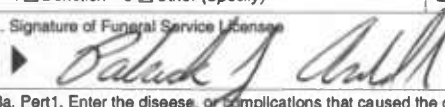
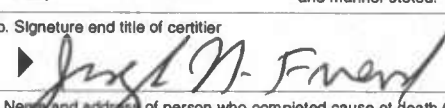
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14886

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard H. Merton</b>				2. Date of Death Month <b>5</b> Day <b>19</b> Year <b>96</b>		3. Time of Death <b>10<sup>5</sup>am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>110-30-7742</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 5, 1939</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Edgewater</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3768 Colliers Drive</b>				10f. Zip Code <b>21037</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1960-62</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Vice President</b>		16b. Kind of Business/Industry <b>Heating/Air Cond.</b>		
17. Father's Name (First, Middle, Last) <b>Bernard Merton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eileen Powers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Grace Merton</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3768 Colliers Drive, Edgewater, MD 21037</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		Date <b>5/22</b>		20c. Location - City or Town, State <b>Davidsonville, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridegely Ave. Annapolis, MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiopulmonary arrest</b> Due to (or as a consequence of): b. <b>Severe coronary artery disease</b> Due to (or as a consequence of): c. <b>Generalized atherosclerosis</b> Due to (or as a consequence of): d. <b>Insulin dependent diabetes mellitus</b>								Approximate Interval Between Onset and Death <b>Immediate</b> <b>Yrs</b> <b>Yrs</b> <b>Yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Diabetic nephropathy &amp; retinopathy</b> <b>Hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>017965</b>		29d. Date signed (Month, Day, Year) <b>5/17/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph N. Friend 205 Ridgeley Ave Annapolis, Md.</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14887

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL EDNA MEDLEY				2. Date of Death May 17, 1996		3. Time of Death 9am		
	4a. Facility Name (If not institution, give street and number) 300 NEVADA AVE.				4b. City, Town, or Location of Death ODENTON		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 218-22-3330		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 27, 1918	9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County A.A. CO.		10c. City, Town or Location ODENTON		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 300 NEVADA AVE.				10f. Zip Code 21113		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABELER		16b. Kind of Business/Industry PAINT COMPANY		
	17. Father's Name (First, Middle, Last) ERNEST CHAMBERS				18. Mother's Name (First, Middle, Maiden Surname) MARIE SEEBOLD				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ROBERT W. MEDLEY HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 NEVADA AVE ODENTON MD				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDEN PARK		Data 5-19-		20c. Location - City or Town, State BALTIMORE MD		
	21. Signature of Funeral Service Licensee <i>Baluch J. Amell</i>				22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD GAMBRILLS MD 21054				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Respiratory Failure</i> Due to (or as a consequence of): b. <i>Carcinoma of the lung</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>few days ~10 mths</i>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>Anemia</i> <i>Osteoarthritis</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Geetha Raja MD</i>		29c. License number D27541		29d. Date signed (Month, Day, Year) May 18, 1996		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) GEEETHA RAJA, 4367 Hollins Ferry Rd, Baltimore MD-21227									
31. Date filed (Month, Day, Year) MAY 21 1996									

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, TT

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14888

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVE (NMN) MITCHELL

2. Date of Death  
Month Day Year  
5 19 19963. Time of Death  
9:30 AM

4a. Facility Name (If not institution, give street and number)

105 BONNIE VIEW RD.

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

212-42-7551

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

7/24/1906

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

105 BONNIE VIEW RD.

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

12

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BUNYON PATTON

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

JUANITA M. MITCHELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 BONNIE VIEW RD., GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK 5/22/96 ELK RIDGE, MARYLAND

Date

5/22/96

20c. Location - City or Town, State

ELK RIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME

1 SECOND AVE. S.W., GLEN BURNIE MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Coronary artery disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart failure,  
Due to (or as a consequence of):

3 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Don. Nussair

29c. License number

D40519.

29d. Date signed (Month, Day, Year)

5.20.96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA M. NUSAIR M.D. 7845 OAKWOOD RD. GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

Julia [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



96 14889

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sophie Leah Newton				2. DATE OF DEATH May 11, 1996		3. TIME OF DEATH 4:00 a.m.	
4. SOCIAL SECURITY NUMBER 020-30-8407		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1911		8. BIRTHPLACE (State or Foreign Country) Massachusetts	
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6111 Montrose Road				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher		16b. KIND OF BUSINESS/INDUSTRY Public Schools			
17. FATHER'S NAME (First, Middle, Last) Michael Staller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Baskin			
19a. INFORMANT'S NAME (Type/Print) Judith E. Samuels				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5207 Bangor Dr., Kensington, MD 20895			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Cemetery 5/15		20c. LOCATION — City or Town, State Falls Church, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Matthew J. Busch</i>				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Home 22201 2847 Wilson Blvd. Arlington, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 15 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chelham MD</i>				29c. LICENSE NUMBER 033224		29d. DATE SIGNED (Month, Day, Year) MAY 11, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Trehan MD 500 Edmonston Dr #401 Rockville MD 20852							
31. DATE FILED (Month, Day, Year) MAY 21 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96-2692-510

CIP ITEMS: 23 PART I, 27, 28a-f, PER  
MEO FILM G-735 5/29/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14890

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHERMAN PLATT				2. Date of Death Month Day Year MAY 17, 1996		3. Time of Death 12:38 PM		
	4a. Facility Name (If not institution, give street and number) 3100 ST. PAUL STREET #812				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 220-46-5837	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 12, 1954		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3100 ST. PAUL ST., APT. 812A			10f. Zip Code 21218		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MALE NURSE		16b. Kind of Business/Industry MEDICINE			
	17. Father's Name (First, Middle, Last) A. ERNEST PLATT				18. Mother's Name (First, Middle, Maiden Surname) RUTH BUTENSKY				
	19a. Informant's Name/Relationship (Type, Print) MR. A. ERNEST PLATT (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3028 MARNAT ROAD BALTIMORE, MD 21208				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO -		Date 5-20-1996		20c. Location - City or Town, State BALTIMORE, MD		
	21. Signature of Funeral Service Licensee <i>Joel D Lewis</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. NARCOTIC INTOXICATION Due to (or as a consequence of):  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: 5/17/96		28b. Time of Injury 12:05 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred UNKNOWN	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) APT. 812A BALTIMORE, MARYLAND					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 18, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 21 1996		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14891

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Angelo M. Ravita				2. DATE OF DEATH MONTH DAY YEAR May 17 1996		3. TIME OF DEATH 7:45 A M	
4. SOCIAL SECURITY NUMBER 216-16-1539		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 13 1924	
9a. FACILITY NAME (If not institution, give street and number) Maple Drive 7100				9b. CITY, TOWN OR LOCATION OF DEATH Dundalk		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Maple Drive 7100				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Dominick Ravita				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Ponticello			
19a. INFORMANT'S NAME (Type/Print) Evelyn Ravita				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maple Dr. 7100 Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St' Stanislaus May 20		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Chojnacki</i>				22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balt., MD. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardia arrhythmia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary artery disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>Seconds</i> <i>20 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D15408		29d. DATE SIGNED (Month, Day, Year) 5/17/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.W. MacDonald M.D. 95. HIGHLAND AVE 21224							
31. DATE FILED (Month, Day, Year) MAY 21 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14892

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUIS SHNIDMAN</b>				2. Date of Death Month <b>MAY</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>1249pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>104-07-7646</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 15, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>3208 NORTHBROOK RD.</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CHEMIST</b>		16b. Kind of Business/Industry <b>ROCHESTER GAS and ELECTRIC</b>					
17. Father's Name (First, Middle, Last) <b>SHIA SHNIDMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH LUSTER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>RABBI DANIEL SHNIDMAN</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5915 BLAND AVE. BALTIMORE, MD 21215</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SHEARITH ISRAEL</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		20d. Location - City or Town, State <b>BOWLEYS LANE</b>			
21. Signature of Funeral Service Licensee <b>Scott M. Cutler</b>				22. Name and Address of Facility <b>LEVINSON AND BROS. INC</b> <b>8900 REISTERSTOWN RD. BALTIMORE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>1 MO.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Chubert</b>				29c. License number <b>A2402321 PL9838</b>	
29d. Date signed (Month, Day, Year) <b>May 15, 1996</b>				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C/O SINAI Hospital, Balt - MD</b>					
30. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				31. Date filed (Month, Day, Year) <b>May 21 1996</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14893

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

SIDNEY STEIN

2. Date of Death

Month

Day

Year

MAY

16

1996

3. Time of Death

10 20 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

216-07-2925

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

08/10/1915

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 POMONA NORTH

APT. #3

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

JACOB

STEIN

18. Mother's Name (First, Middle, Maiden Surname)

GOLDIE

MOLDOFSKY

19a. Informant's Name/Relationship (Type, Print)

ANNA SYLVIA STEIN / SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 POMONA NORTH, APT. 3 PIKESVILLE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK

Date

5/17/96

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi

29c. License number

D37333

29d. Date signed (Month, Day, Year)

MAY 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI MD, ALTO, BALTO. MD 21133.

31. Date of Death (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

Julia R. Ravi

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

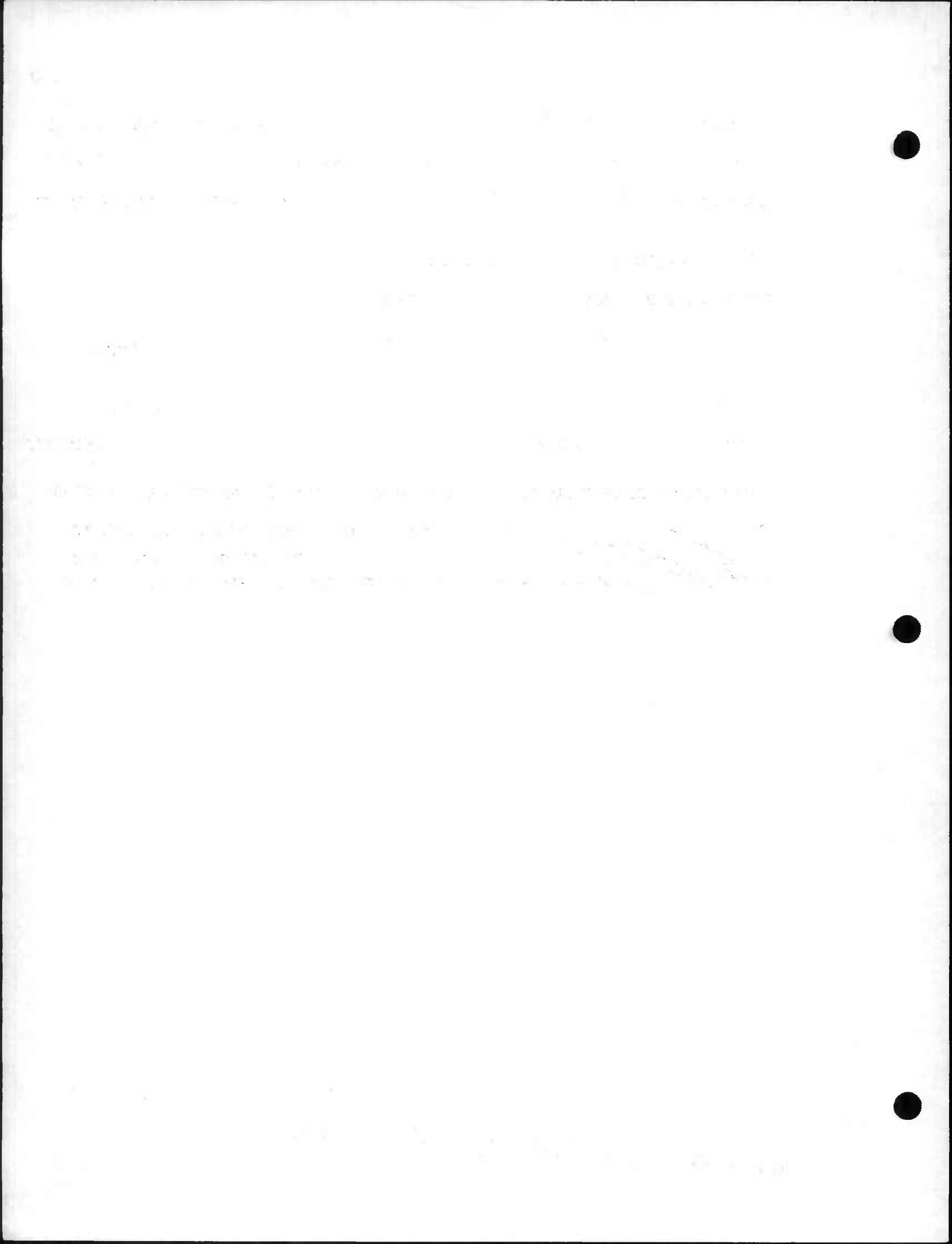
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Westley</b>			2. Date of Death Month Day Year <b>MAY 19, 1996</b>			3. Time of Death <b>3:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1738 N. PULASKI ST.</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death		
Funeral Director	5. Social Security Number <b>244-05-8644</b>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG 18, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>N.C.</b>			10e. State <b>MARYLAND</b>			10b. County		
To Be Completed by Funeral Director	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10f. Zip Code <b>21217</b>		
	10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HEALTH CARE</b>		
	16. Kind of Business/Industry <b>U.S. GOVT.</b>			17. Father's Name (First, Middle, Last) <b>JOSEPH B SUTTON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MELISSA G THAGGART</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>LETITIA BUCKLEY</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2221 BRADDISH AVE BALT. MD 21216</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL MEM. PK.</b>			20c. Location - City or Town, State <b>5/24/96 13300 WASH. BLVD. LAUREL</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Donald E. Glover</b>			22. Name and Address of Facility <b>1701 McCulloh ST BALT. MD 21217</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>strangulation</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>5-19-96</b>			28b. Time of Injury <b>1515</b> M		
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred <b>subject strangled</b>			28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>1738 N Pulaski St</b>		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>David R Fowler</b>			29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>MAY 20, 1996</b>		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature <b>John Dawson-Rodell</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is arranged in several paragraphs across the page.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14895

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANN F. SILBERMAN</b>						2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>1:25 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>						4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>220-09-9759</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 2, 1902</b>		9. Birthplace (State or Foreign Country) <b>UNOBTAINABLE</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>6101 PARK HEIGHTS AVE., APT. 2-C</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>UNKNOWN</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>			
	17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ARTHUR DRAGER (ATTY.)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 LIGHT ST., SUITE 510 BALTIMORE, MD 21202</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		Date <b>5/20/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>				
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASPIRATION PNEUMONIA</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>1 WEEK</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration</b> <b>Alzheimer's Disease</b>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>A.J. IMPERIAL, Jr.</b>		29c. License number <b>D44505</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.J. IMPERIAL, Jr. - NEW #</b>											
31. Date (Month, Day, Year) <b>MAY 27 1996</b>		32. Registrar's Signature 									

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14896

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joy JEAN SHOEMAKER</b>				2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1996</b>		3. Time of Death <b>0957 A</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>520-16-4050</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 9, 1921</b>		
	9. Birthplace (State or Foreign Country) <b>MISSOURI</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>CLARKSBURG</b>		
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>			10b. County <b>MONTGOMERY</b>			10c. City, Town or Location <b>CLARKSBURG</b>			
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>23800 RIDGE ROAD</b>			10f. Zip Code <b>20871</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATIVE ASSISTANT</b>			
16b. Kind of Business/Industry <b>U.S. GOVERNMENT</b>			17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PATRICK L. SHOEMAKER, SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7513 CAMP ALGER AVENUE, FALLS CHURCH, VA. 22042</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LAYTONSVILLE CEMETERY</b>			Date <b>5/20/96</b>		20c. Location - City or Town, State <b>LAYTONSVILLE, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>Muriel H. Barber</b>			22. Name and Address of Facility <b>MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038 LAYTONSVILLE, MARYLAND 20882</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): c. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): d.									
Approximate Interval Between Onset and Death <b>1 WK</b> <b>3 WKS</b> <b>4 YRS</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, RENAL FAILURE, HYPERTHYROID</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Steven T. Kariya - MD</b>			29c. License number <b>D36252</b>			29d. Date signed (Month, Day, Year) <b>MAY 16, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN T. KARIYA, MD, 11501 GEORGIA AVE STE 55, WHEATON MD 20902</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's Signature <b>John Anderson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14897

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLOVER B. STREET</b>				2. Date of Death Month <b>May</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>3:45 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2111 Pulaski St.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>705-12-4373</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 28, 1910</b>	
	Usual Residence of Decedent		10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>2111 Pulaski St.</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waiter</b>		16b. Kind of Business/Industry <b>B+O. Railroad</b>			
	17. Father's Name (First, Middle, Last) <b>Elize Street, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Womble</b>			
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Dolores Plummer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3206 Dorithan Rd. Balto, Md. 21215</b>			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn</b>		20c. Location - City or Town, State <b>Balto, Md.</b>		20d. Date <b>5/21/96</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>James G. Morton</b>				22. Name and Address of Facility <b>James A. Morton &amp; Sons 1701 Laurens St. Balto, Md. 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebrovascular Disease</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Cardiovascular Disease.</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		26a. Date of Injury (Month, Day Year)		26b. Time of Injury <b>M</b>		26c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>George Taler, M.D.</b>			
	29c. License number <b>D19858</b>				29d. Date signed (Month, Day, Year) <b>May 17, 1996</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>George Taler, M.D. 2200 Kervan Dr. Baltimore, Md. 21207</b>							
	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature <b>Donna Randall</b>			







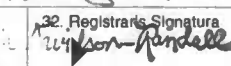
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14898

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stephen Walter Smith</b>				2. Date of Death Month <b>May</b> Day <b>14</b> , Year <b>1996</b>		3. Time of Death <b>1801</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>220-52-7394</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1947</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Brighton</b>	
Usual Residence of Decedent								
10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Brighton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>6509 Mt. Vernon Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>---</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bill Collector</b>			16b. Kind of Business/Industry <b>Medical Expenses</b>	
17. Father's Name (First, Middle, Last) <b>Frank Walter Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ardath Marie Wenzel</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bettie L. Smith (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6509 Mt. Vernon Avenue Baltimore, Maryland 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		20c. Location - City or Town, State <b>Sykesville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133-4784</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Cardiac Arrest</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Swollen Left Ankle</b> <b>Anxiety.</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>014753</b>		29d. Date signed (Month, Day, Year) <b>5/15/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>800 L. Beth Pleasant Hill, 1 Randallstown, Maryland 21133</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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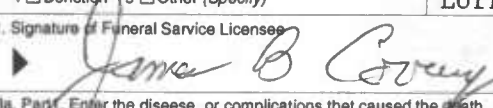
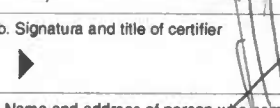
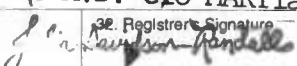
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State of Maryland / Department of Health and Mental Hygiene

96 14899

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Beatrice Scarborough</b>				2. Date of Death Month <b>May</b> Day <b>11</b> Year <b>1996</b>				3. Time of Death <b>4.20 P</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-03-6613</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1904</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2211 W. Rogers Ave.</b>		10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>Stewarts Dept. Store</b>		17. Father's Name (First, Middle, Last) <b>Clarence R. Scarborough</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Porter</b>		19a. Informant's Name/Relationship (Type, Print) <b>Bernice J. Depro Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1909 Oak Ave. Baltimore, MD 21207</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		Date <b>5/15/96</b>		20c. Location - City or Town, State <b>Woodlawn, MD</b>		21. Signature of Funeral Service Licensee 	
Physician /Medical Examiner	22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pulmonary Edema</b> Due to (or as a consequence of): <b>Acute Renal Failure</b> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Cerebrovascular Accident</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier  <b>Luis Mejido M.D.</b>		29c. License number <b>89246</b>		29d. Date signed (Month, Day, Year) <b>May 11, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Luis Mejido M.D. 670 MARYLAND GENERAL HOSPITAL</b>		31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>	
State Registrar		32. Registrar's Signature 								



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State of Maryland / Department of Health and Mental Hygiene

96 14900

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Herman Stiegler, Jr.				2. Date of Death Month Day Year May 14 1996		3. Time of Death 6:30A.M.	
	4a. Facility Name (If not Institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-32-7843	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	8. Under 1 Year Months Days	8. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 4, 1903		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 201 St. Mark Way				10f. Zip Code 21158		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Plumber			16b. Kind of Business/Industry Allied Plumbing and Heating	
17. Father's Name (First, Middle, Last) William Herman Stiegler, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Alverta Parker				
19a. Informant's Name/Relationship (Type, Print) Wilhelmina Stiegler Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 St. Mark Way Westminster, MD 21158				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 5/17/96		20d. Location - City or Town, State Woodlawn, MD		
21. Signature of Funeral Service Licensee James B. Cooper				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Howard G. Lanham				29c. License number D17040		29d. Date signed (Month, Day, Year) May 15, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard G. Lanham, M.D. 215 Wash Hgts Med Ctr Westminster, MD 21157								
31. Date filed (Month, Day, Year) MAY 21 1996				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

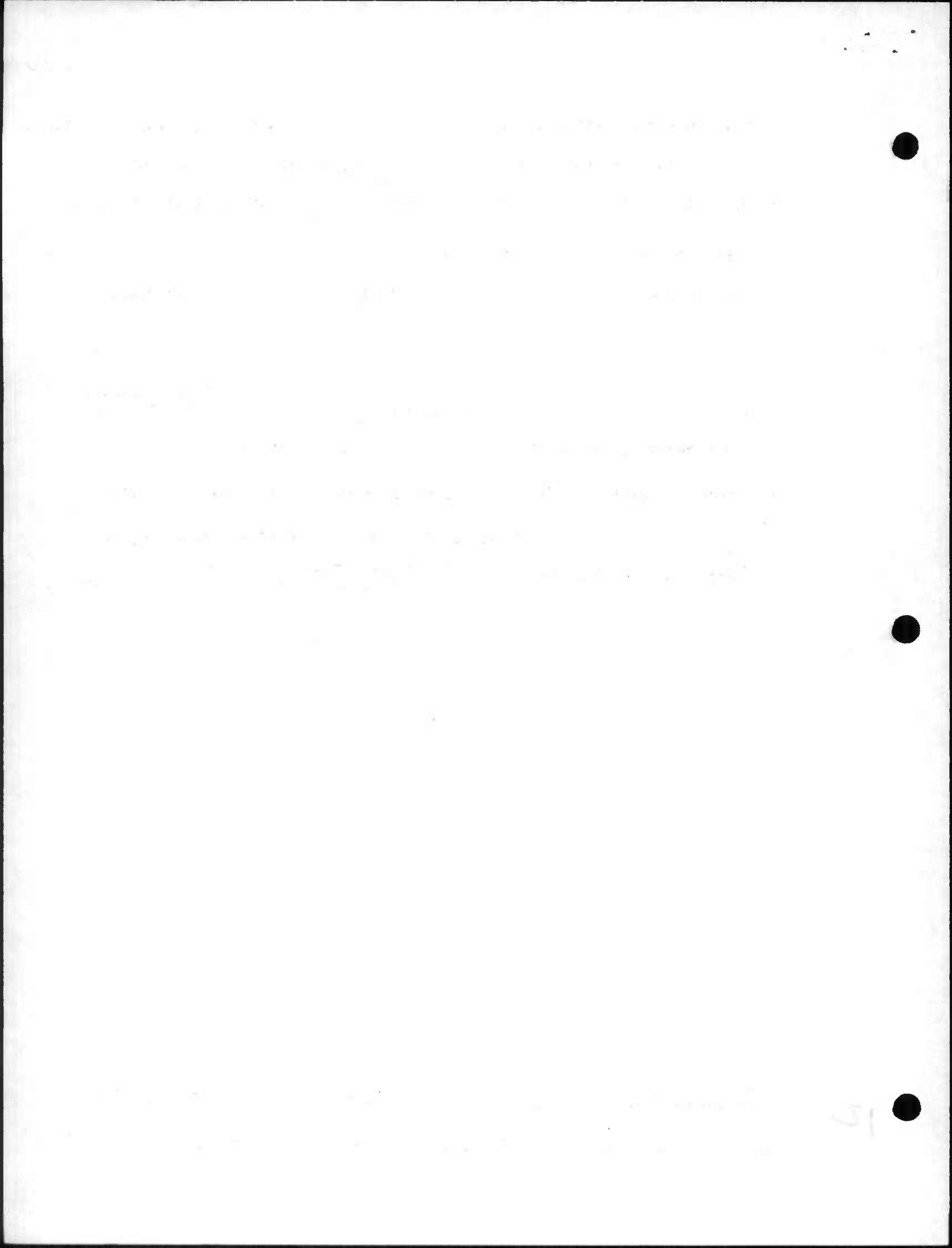
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14901

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Clarence Sanders				2. Date of Death Month Day Year May 20 1996		3. Time of Death 2:15 A.M.	
	4a. Facility Name (If not institution, give street and number) 10 1/2 Old Court Road				4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-07-4887 A	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) March 23, 1907	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Pikesville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 10 1/2 Old Court Road		10f. Zip Code 21208		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction Company			
	17. Father's Name (First, Middle, Last) Jacob A. Sanders				18. Mother's Name (First, Middle, Maiden Surname) Alice M. O'Connor			
	19a. Informant's Name/Relationship (Type, Print) Mr. William Sanders Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 1/2 Old Court Road Pikesville, MD 21208			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Date 5/22/96		20d. Location - City or Town, State Pikesville, MD	
	21. Signature of Funeral Service Licensee <i>James B. Covey</i>		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Brain metastases</i> Due to (or as a consequence of): b. <i>lung carcinoma</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 2-3 mos ?							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>James B. Covey</i>		29c. License number D24214		29d. Date signed (Month, Day, Year) 5/21/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Drake MD, GBMC Radiation Oncology, 6701 N. Charles, Belt 21204								
31. Date filed (Month, Day, Year) MAY 21 1996		32. Registrar's Signature <i>John A. ...</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14902

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Angeline C Seck</b>				2. Date of Death Month Day Year <b>May 19 1996</b>		3. Time of Death <b>11:17 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie, MD</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>579-22-7949</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 1, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>							
To Be Completed by Funeral Director	Usual Residence of Decedant							
	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crofton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>937 Truro Lane</b>				10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collegia (1-4or 5+)				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Confidential Assistant</b>		16b. Kind of Business/Industry <b>Justice Department</b>	
	17. Father's Name (First, Middle, Last) <b>Joseph Cass</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie DiRosa</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Marie T. Knobel</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>937 Truro Lane, Crofton, MD 21114</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cem.</b>		Data <b>5/28</b>		20c. Location - City or Town, State <b>Arlington, VA</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>End stage renal disease</b> <b>Atherosclerotic Cardiovascular disease</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier M.D.				29c. License number <b>D-47423</b>		29d. Date signed (Month, Day, Year) <b>May - 19 - 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali Saifi, North Arundel Hospital, 301 Hospital Drive, Glen Burnie, MD 21061.</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

1. The first part of the report is devoted to a general description of the project and its objectives. It also includes a brief review of the literature on the subject.

2. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

3. The third part of the report presents the results of the study. This includes a detailed description of the data, the results of the statistical analysis, and a discussion of the findings.

4. The fourth part of the report discusses the implications of the findings and provides recommendations for future research. It also includes a conclusion and a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14903

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Donald C. Sines</i>			2. Date of Death Month <i>May</i> Day <i>11</i> Year <i>1996</i>			3. Time of Death <i>1258 P</i>								
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>			4b. City, Town, or Location of Death <b>GAITHERSBURG</b>			4c. County of Death <b>MONTGOMERY</b>								
Funeral Director	5. Social Security Number <b>579-30-1047</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 13, 1928</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>WV</b>		10b. County <b>BERKELEY</b>		10c. City, Town or Location <b>FALLING WATERS</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number <b>1024 WHIPPOORWILL LANE</b>				10f. Zip Code <b>25419</b>			10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1942-1945</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ACCOUNTANT</b>			16b. Kind of Business/Industry <b>NASA</b>							
	17. Father's Name (First, Middle, Last) <b>COLUMBUS B. SINES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAUDE MAE REAMS</b>										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>EDITH S. SINES</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1024 WHIPPOORWILL LANE, FALLING WATERS, WV 25419</b>										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TAYLOR SINES FAMILY CEM.</b>		Date <b>5/14/96</b>		20c. Location - City or Town, State <b>OAKLAND, MD</b>						
	21. Signature of Funeral Service Licensee <i>Charles M. Brown</i>				22. Name and Address of Facility <b>BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25401</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Acute Myeloblastic Leukemia</i> Due to (or as a consequence of): <i>b. Myelodysplastic Syndrome</i> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death <i>6 Months</i> <i>1 year</i>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <i>Joseph M. Haggerty MD</i>		29c. License number <b>D32407</b>		29d. Date signed (Month, Day, Year) <b>May 11, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph M. Haggerty MD 9707 Medical Center Drive Rockville, Maryland 20850</b>															
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>			32. Registrar's signature <i>Davidson-Rendell</i>												



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14904

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Carolyn Sloper			2. Date of Death Month Day Year May 09, 1996		3. Time of Death 8:15 A.	
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital			4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 578-18-3027		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 17, 1914
	9. Birthplace (State or Foreign Country) N. Carolina						
To Be Completed by Funeral Director	10a. State Md.		10b. County Charles		10c. City, Town or Location LaPlata		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street end Number 10200 LaPlata Rd		10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Charles B. Price			18. Mother's Name (First, Middle, Maiden Surname) Maggie Lee Walker			
	19a. Informant's Name/Relationship (Type, Print) Mary A. Jones (Daughter)			19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7403 Parkwood Ct. #203 Falls Church, Va. 22042			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Mem. Park		Date 5/11/96	20c. Location - City or Town, State Falls Church, Va	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MURRAY FALLS CHURCH FH. 1102 W BROAD RD VA 22042				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. atherosclerosis Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how Injury occurred
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D-22574		29d. Date signed (Month, Day, Year) 5/19/96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Pace, MD. Waldorf Medical Park P.O. Box 249 Waldorf, Maryland 20604-0249						
State Registrar	31. Date filed (Month, Day, Year) MAY 21 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.


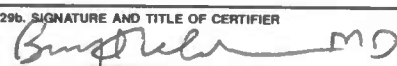

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 14905

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hilda S. Stearman				2. DATE OF DEATH MONTH DAY YEAR May 9, 1996		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 070-28-7235		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
6. DATE OF BIRTH (Month, Day, Year) Oct. 28, 1899				7. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6121 Montrose Road				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Joseph Sokol				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mollie Berkowitz			
19a. INFORMANT'S NAME (Type/Print) Joel Stearman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8506 Wild Olive Drive, Rockville, MD 20854			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) B'Nai Israel Cemetery		DATE 5/12		20c. LOCATION — City or Town, State Oxon Hill, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Home 22201 2847 Wilson Blvd. Arlington, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cerebrovascular accident					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. Arteriosclerotic cerebrovascular disease					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c.					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D23958		29d. DATE SIGNED (Month, Day, Year) 5/10/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Burt I. Feldman MD, 6105 Montrose Rd, Rockville MD 20852							
31. DATE FILED (Month, Day, Year) MAY 21 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEM: 1. PER F.H. FILM G-735 5/21/96  
t.t

State of Maryland / Department of Health and Mental Hygiene

96 14906

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALVIN ELVIN SCOTT</b>				2. Date of Death Month Day Year <b>MAY 19, 1996</b>		3. Time of Death <b>2240 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL E.R.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>MD</b>	
Funeral Director	5. Social Security Number <b>216-50-0870</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04-01-48</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>2310 Ashland Avenue</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> X Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> X No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lab. Assistant</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Elvin Trusty</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Felice Scott</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Felice Scott - mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2310 Ashland Avenue Baltimore, MD 21205</b>			
	20e. Method of Disposition <b>1</b> X Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>5-24-96</b>		20c. Location - City or Town, State <b>Randallstown, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie F/H P.A. 638 N. Gilman Street 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown								
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No								
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> X Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> X ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> X Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year) <b>FOUND ON 5/19/96</b>		28b. Time of Injury <b>UNKNOWN</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> X No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28d. Describe how injury occurred <b>UNKNOWN</b>			
			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2310 ASHLAND AVE. BALTIMORE, MARYLAND</b>					
	29e. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MAY 20, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14907

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hazel Estelle SPAETH				2. Date of Death Month Day Year May 18, 1996		3. Time of Death 12:40 Am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-62-0952		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		6. Date of Birth (Month, Day, Year) Dec 23, 1900	
	9. Birthplace (State or Foreign Country) New York		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex	
Usual Residence of Decedent								
10a. State Md.			10b. County Baltimore			10c. City, Town or Location Essex		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 2 Helena Ave.			10f. Zip Code 21221		
10g. Citizen of What Country? USA			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed			16b. Kind of Business/Industry Candle Factory			17. Father's Name (First, Middle, Last) unknown		
18. Mother's Name (First, Middle, Maiden Surname) unknown			19a. Informant's Name/Relationship (Type, Print) Barry Fennell			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Stoney Brook Road Fallston Md. 21047		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Assumption Cemetery			20c. Location - City or Town, State Syracuse New York		
21. Signature of Funeral Service Licensee R. Terry Connelly			22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) e. Atherosclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death 20 years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident Seizure Disorder Hypothyroidism, Dementia								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Naeem Gauhar MD								
29c. License number D18326								
29d. Date signed (Month, Day, Year) 5/18/96								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Naeem Gauhar 9000 Franklin Square Drive Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) MAY 21 1996								
32. Registrar's Signature Julia Davidson-Randall								

1

State of Maryland / Department of Health and Mental Hygiene

96 14908

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONARD THOMAS</b>				2. Date of Death Month <b>MAY</b> 11, Day <b>1996</b> Year		3. Time of Death <b>2:10PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>216-05-2324</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 10, 1906</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>300 International Circle</b>				10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>unknown</b>		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Moving and Storage</b>				
	17. Father's Name (First, Middle, Last) <b>Edward R. Thomas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nanie Elizabeth Stickel</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Susan Denton, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 468 Queenstown, Maryland 21658</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>				22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201-1559</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. <b>STROKE</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PROSTATE CANCER</b> <b>ATRIAL FIBRILLATION.</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>N. Rosenblum MD</b>				29c. License number <b>D23319</b>		29d. Date signed (Month, Day, Year) <b>MAY 12 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. ROSENBLUM MD 7600 OSLER DRIVE TOWSON MD 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14909

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Theodore Tragas</b>				2. Date of Death Month <b>May</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>5:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218 58 3511</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1928</b>	9. Birthplace (State or Foreign Country) <b>Greece</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4402 - 4th Street</b>				10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>Canadian</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Restaurant Owner</b>		16b. Kind of Business/Industry <b>Self Employed</b>	
	17. Father's Name (First, Middle, Last) <b>George Tragas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lilly Matalas</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>George Tragas</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Burwood Road Glen Burnie, Maryland 21061</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greek Orthodox Cemetery</b>		Date <b>5/21/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Jerome Grammoussi</b>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death) <b>a. Gastrointestinal Bleed</b> Due to (or as a consequence of): <b>b. Metastatic Hepatocellular Carcinoma</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>24 hours</b> <b>6 months</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Craig M. Intern</b>		29c. License number <b>N4326</b>		29d. Date signed (Month, Day, Year) <b>May 18, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 North Wolfe Street, Baltimore, Maryland 21205</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <b>John Davidson-Rodriguez</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

[illegible]



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State of Maryland / Department of Health and Mental Hygiene

96 14910

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louella Tarr</b>				2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1996</b>				3. Time of Death <b>4 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>379 Alameda Parkway</b>				4b. City, Town, or Location of Death <b>Arnold</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>220-01-5914</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>March 29, 1913</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>379 Alameda Parkway</b>		10f. Zip Code <b>21012</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Saleslady</b>	
	16b. Kind of Business/Industry <b>GC Murphy Co.</b>		17. Father's Name (First, Middle, Last) <b>Sampson Nicholas Elza</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Rosetta Cromer</b>		19a. Informant's Name/Relationship (Type, Print) <b>Wilson Edward Tarr</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>179 Topeg Drive Severna Park, Maryland 21146</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <i>Judy Henss Carpenter</i>		22. Name and Address of Facility <b>Burgess-Henss Funeral Home 3631 Falls Road Balto., MD 21211</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head trauma. List only one cause on each line. <b>esophageal cancer</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death <b>10 mos.</b>	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Stuart E. Selouch, M.D.</i>		29c. License number <b>019838</b>		29d. Date signed (Month, Day, Year) <b>5/17/96</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart E. Selouch, M.D. 900 Bestgate Annapolis, Md. 21401</b>	
	31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature <i>J. A. Davidson-Randall</i>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>State Registrar</b>		35. Registrar's Phone <b>410-527-1000</b>	

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

96 14911

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Robert Lee Thompson, Jr.</b>				2. Date of Death Month <b>May</b> , Day <b>19</b> , Year <b>1996</b>		3. Time of Death <b>7:30 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2715 1/2 Bachman Rd.</b>				4b. City, Town, or Location of Death <b>Manchester</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>212-44-7510</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 7, 1944</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedant							
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Manchester</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2715 1/2 Bachman Rd.</b>				10f. Zip Code <b>21102</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1962-1968</b>		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Asst. Manager</b>		16b. Kind of Business/Industry <b>Food</b>	
	17. Father's Name (First, Middle, Last) <b>Robert Lee Thompson, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Croissant</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Terry Thompson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2715 1/2 Bachman Rd., Manchester, Md. 21102</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens</b>		20c. Location - City or Town, State <b>05/21/96 Finksburg, Md.</b>		20d. Location - City or Town, State <b>21102</b>	
	21. Signature of Funeral Service Licensee <b>H. J. Ehrhardt</b>				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md.</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> <b>a. METASTATIC ADENOCARCINOMA</b> Dua to (or as a consequence of):  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier <b>Flavio Kruter MD</b>				29c. License number <b>D35392</b>		29d. Date signed (Month, Day, Year) <b>5/21/96</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Flavio Kruter, MD 684 A Poole Rd. - Westminster, MD 21157</b>								
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>				32. Registrar's Signature <b>Julia Davidson-Rendall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 14912

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Eliza Unkart				2. Date of Death Month Day Year May 17, 1996		3. Time of Death 11:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 4403 Forest View Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-07-0692	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 29, 1907	9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4403 Forest View Avenue			10f. Zip Code 21206		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade Collega (1-4or 5+) Collega		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) William Unknown DeSchon				18. Mother's Name (First, Middle, Maiden Surname) Eliza Unknown Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara A. Smolinski P.R.Estate				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Rico Drive Selbyville Delaware-19975			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 5/21/96	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee Kathleen M. Murphy			22. Name and Address of Facility 6415 Belair Road John C. Miller, Inc. Baltimore, Maryland-21206				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Acute Cerebrovascular Accident</p> <p>b. Arteriosclerotic Cardiovascular Disease</p> <p>c.</p> <p>d.</p> </div> <div> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> </div>							Approximate Interval Between Onset and Death 1 wk.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how Injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier [Signature]			29c. License number D19423		29d. Date signed (Month/Day, Year) 5/20/96		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Wd. Revere Blvd Baltimore, Md 21239							
	31. Date filed (Month, Day, Year) MAY 21 1996				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14913

Item 17, 18, 19a, 19b, Film 735, 5/29/96, 1t

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ILEANA FLORENCE

VANMATER

2. Date of Death

Month

Day

Year

May

17

1996

3. Time of Death

9:05 P.M.

4e. Facility Name (If not institution, give street and number)

Ginger Cove

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-42-4773

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 24, 1914

9. Birthplace (State or Foreign Country)

Rumanio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

4000 River Crescent Drive

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Retail Clothing

17. Father's Name (First, Middle, Last)

Ernest Chambers

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Marie Seebold

PROTOPAPESCU

19a. Informant's Name/Relationship (Type, Print)

Robert Watson Medley

ALAN E. THORNTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Nevada Ave Odenton, MD 21113

415 RUSSELL AVE #816, CATTESBURG, MARYLAND 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

5/20

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Balak J. [Signature]

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD

21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John J. [Signature] MD

29c. License number

D3018

29d. Date signed (Month, Day, Year)

5-20-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Jackson 2002 1st. Key #100 Annapolis MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1996

32. Registrar's Signature

Julia [Signature] Rondelle

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68766

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and the limitations of the study.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and the conclusions drawn from the study.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.



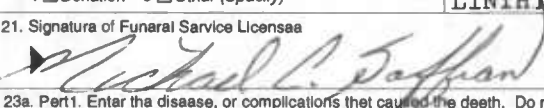
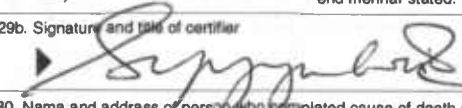
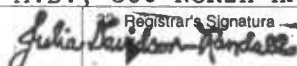
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14914

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATILDA PHILLIPS VICKREY</b>				2. Date of Death Month <b>MAY</b> Day <b>18</b> , Year <b>1996</b>		3. Time of Death <b>12:50 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>102 W. MAPLE ROAD</b>				4b. City, Town, or Location of Death <b>LINTHICUM</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>214-62-0540</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07-14-1909</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State <b>MARYLAND</b>	10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>LINTHICUM</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>102 W. MAPLE ROAD</b>			10f. Zip Code <b>21090</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>			
	17. Father's Name (First, Middle, Last) <b>WADE HAMPTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY DELMAH BROWN</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>LUSTER AZIL VICKREY, JR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 W. MAPLE ROAD, LINTHICUM, MD. 21090</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LINTHICUM FAMILY CEMETERY</b>		Data <b>5/21/96</b>		20c. Location - City or Town, State <b>LINTHICUM, MD.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) <b>a. LUNG CANCER</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequitally list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Approximate Interval Between Onset and Death <b>2 weeks</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D40491</b>		29d. Date signed (Month, Day, Year) <b>MAY 18 1996</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>DR. SYED RIAZ, M.D., 800 NORTH HAMMONDS FERRY LANE, STE 1B, LINTHICUM, MD. 21090</b>									
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as a burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

AMMONDE

1040

96 14915

ITEMS: 1.10a-f,12,15,16a,16b,18,19,19b, PER F.H. FILM 6-735 5/21/96 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DR. ALBERT EDWARD WEINER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>05 19 1996</b>		3. TIME OF DEATH <b>3:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>006-18-8331</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-5-17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SPRINGFIELD HOSP. CTR.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SYKESVILLE, MD</b>		9c. COUNTY OF DEATH <b>CARROLL</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE SYKESVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6655 SYKESVILLE RD.</b> <b>18 ORCHARD WAY SOUTH</b>		10f. ZIP CODE <b>20854 21784</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+) 5t</b> <b>PHYSICIAN</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OB-GYN PHYSICIAN</b>				16b. KIND OF BUSINESS/INDUSTRY <b>MEDICINE</b>		17. FATHER'S NAME (First, Middle, Last) <b>HYMAN WEINER</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DESSIE SAYE</b>				19a. INFORMANT'S NAME (Type/Print) <b>E. DE LA CRUZ, MD (SON)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>(ABOVE) 1902 YAUPON VALLEY RD. AUSTIN, TX 78746</b>	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH EL CEM.</b>		20c. LOCATION — City or Town, State <b>5/20/96 BOSTON, MA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIABETES MELITUS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>10 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA &amp; R-sided weakness &amp; difficulty swallowing, causing aspiration pneumonia at times</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>E. de la Cruz MD</b>				29c. LICENSE NUMBER <b>D29531</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-19-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDUARDO DE LA CRUZ, MD Springfield Hosp. Ctr., Sykesville, MD 21784</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 21 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

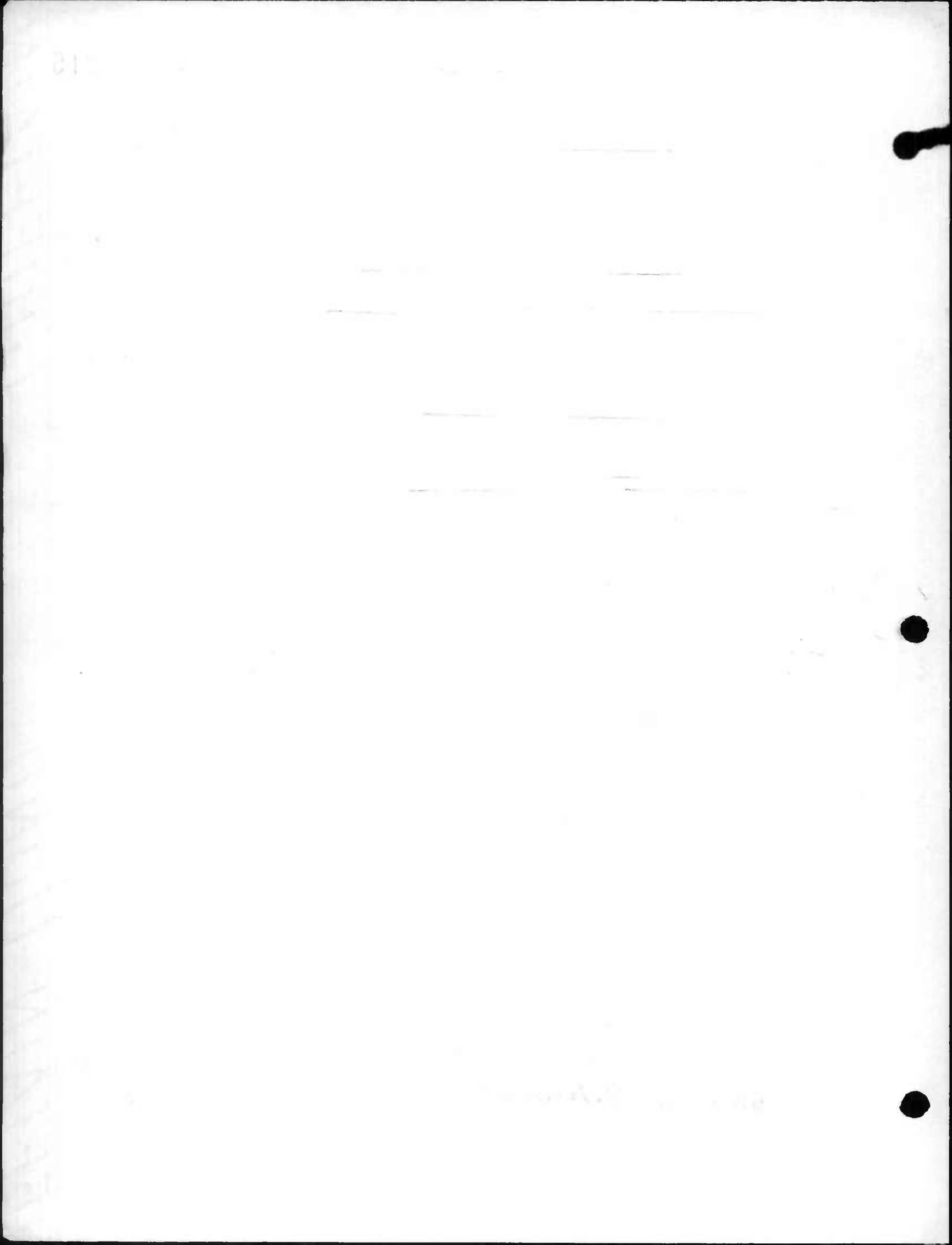
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

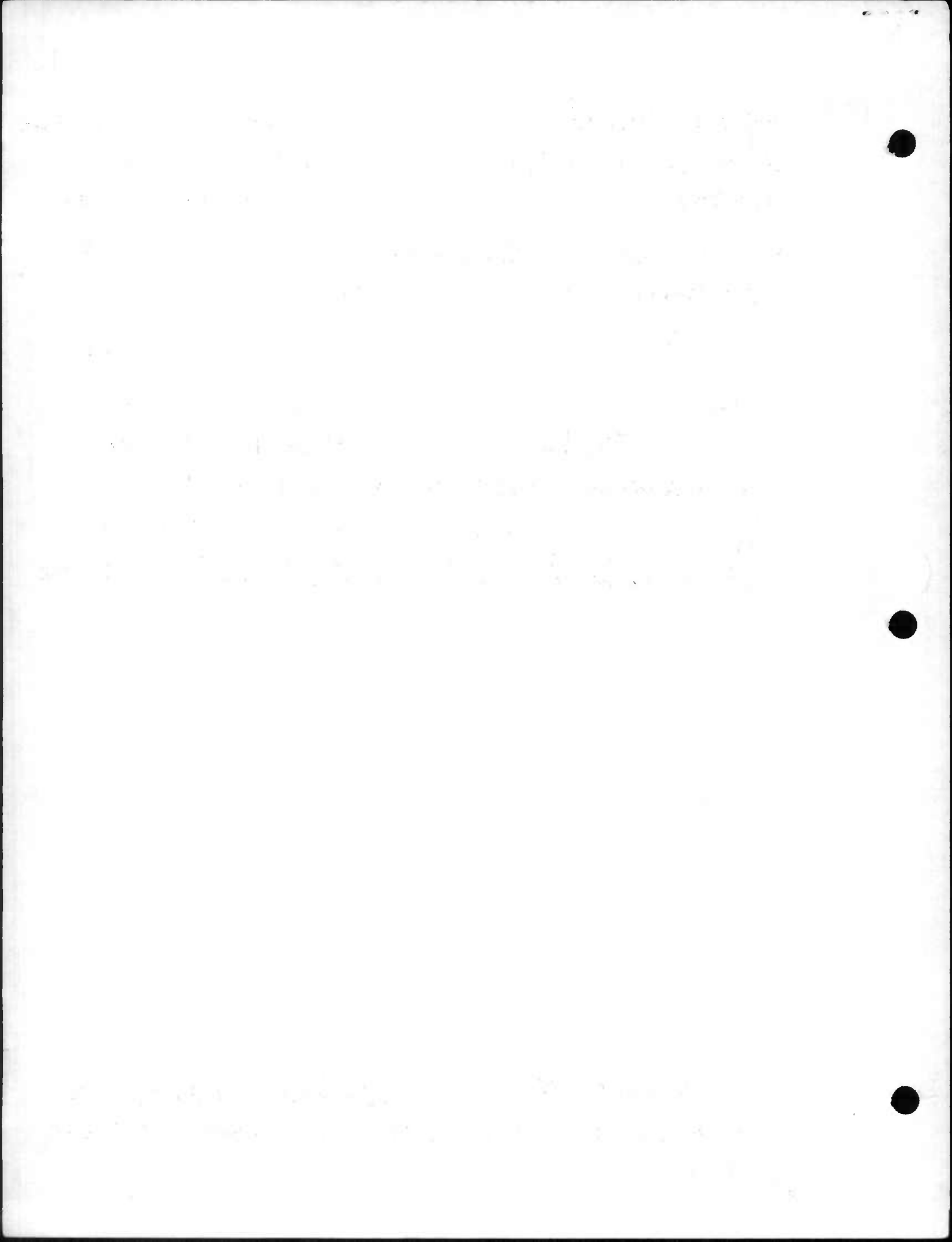
State of Maryland / Department of Health and Mental Hygiene

96 14916

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY B. WILSON</b>				2. Date of Death Month <b>05</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>8:25 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL (SUB-ACUTE)</b>				4b. City, Town, or Location of Death <b>BALTO. CITY</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>212-12-9117</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-16-1917</b>	
	9. Birthplace (State or Foreign Country) <b>VA</b>		10e. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		10h. Street and Number <b>2167 Baker Street</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Presser</b>		16b. Kind of Business/Industry <b>Continental Can Company</b>		17. Father's Name (First, Middle, Last) <b>Bailey</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah White</b>		19a. Informant's Name/Relationship (Type, Print) <b>William A. Wilson-Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2167 Baker St. BALTO MD 21216</b>		20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem Park</b>		20c. Location - City or Town, State <b>Balto Md</b>		21. Signature of Funeral Service Licensee <b>Phyllis B. Harris</b>		22. Name and Address of Facility <b>MARCH FUNERAL HOME-EAST 1101 E. NORTH AVE. BALTO MD. 21202</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure</b> Due to (or as a consequence of): <b>b. mitral valve insufficiency</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>5 years</b> <b>5 years</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>CD Kearney MD</b>	
	29c. License number <b>D27860</b>		29d. Date signed (Month, Day, Year) <b>MAY 18, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CHRISTOPHER D. KEARNEY 700 WASHINGTON BLVD BALT MD 21230</b>		31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>	
32. Registrar's Signature <b>Julia Davidson-Rodella</b>		33. Date of Death <b>96 14916</b>		34. State Registrar <b>MD</b>		35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		



96 14917

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Robert F. Wuenschel, Sr.</i>				2. DATE OF DEATH MONTH <i>05</i> DAY <i>19</i> YEAR <i>96</i>		3. TIME OF DEATH <i>10:15 A M</i>	
4. SOCIAL SECURITY NUMBER <i>170-16-3817</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 16, 1919</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Westminster Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i>	
9c. COUNTY OF DEATH <i>Carroll</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore County</i>	
10c. CITY, TOWN OR LOCATION <i>Randallstown</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>3452 Carriage Hill Circle Apt. 101</i>	
10f. ZIP CODE <i>21133</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WW OR DATES <i>WWII</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Postal Worker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Postal Service</i>			
17. FATHER'S NAME (First, Middle, Last) <i>George Wuenschel</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella Lyons</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. John E. Wuenschel (son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5070 Amantea Way Sykesville, MD 21784</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lake View Memorial Park 5/22/96 Sykesville, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian J. Haight</i>				22. NAME AND ADDRESS OF FACILITY <i>HAIGHT FUNERAL HOME &amp; CHAPEL (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerosis Coronary Vessel Disease</i> Approximate Interval Between Onset and Death <i>10 yrs</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebral Vascular Accident</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>5/12/96</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Moss, MD</i>				29c. LICENSE NUMBER <i>032882</i>			
29d. DATE SIGNED (Month, Day, Year) <i>5/12/96</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert L. Moss, MD 114 Business Center Dr. Randallstown, MD 21136</i>			
31. DATE FILED (Month, Day, Year) <i>MAY 21 1996</i>				32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14918

Film G735 item 1 per FH 5-21-96 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Wilson <del>JR.</del> SR.				2. Date of Death Month Day Year May 14, 1996		3. Time of Death 6:30 Am	
	4a. Facility Name (If not institution, give street and number) 3315 Edmondson Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-30-3094		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) March 15, 1934	
	9. Birthplace (State or Foreign Country) md		10a. State md		10b. County N/A		10c. City, Town or Location Balto	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3315 Edmondson Ave		10f. Zip Code 21229	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 10/15/60 thru 7/10/58	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift operator				16b. Kind of Business/Industry Pepsi (Soda Co)			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Decosie Wilson				18. Mother's Name (First, Middle, Maiden Surname) Viola Snowden			
	19a. Informant's Name/Relationship (Type, Print) Muriel Wilson - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 Edmondson Ave Balto, md 21229			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garson Forest vet		20c. Location - City or Town, State 5/20/96 Owings Mills, md	
	21. Signature of Funeral Service Licensee Jale March				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215			
To Be Completed by Physician/Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. CORONARY ARTERY DISEASE Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Catherine Staropoli MD			
To Be Completed by Physician/Medical Examiner	29c. License number D47650				29d. Date signed (Month, Day, Year) 5/15/95			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATHERINE STAROPOLI MD BALTIMORE VAMC				31. Date filed (Month, Day, Year) MAY 21 1996			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature J. Davidson-Randall				33. State Registrar			
	34. State Registrar				35. State Registrar			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

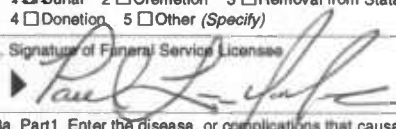

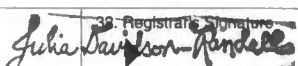
Medical Certification: To Be Completed by Physician/Medical Examiner



Item 1, Film 735, 5/29/96, 1t

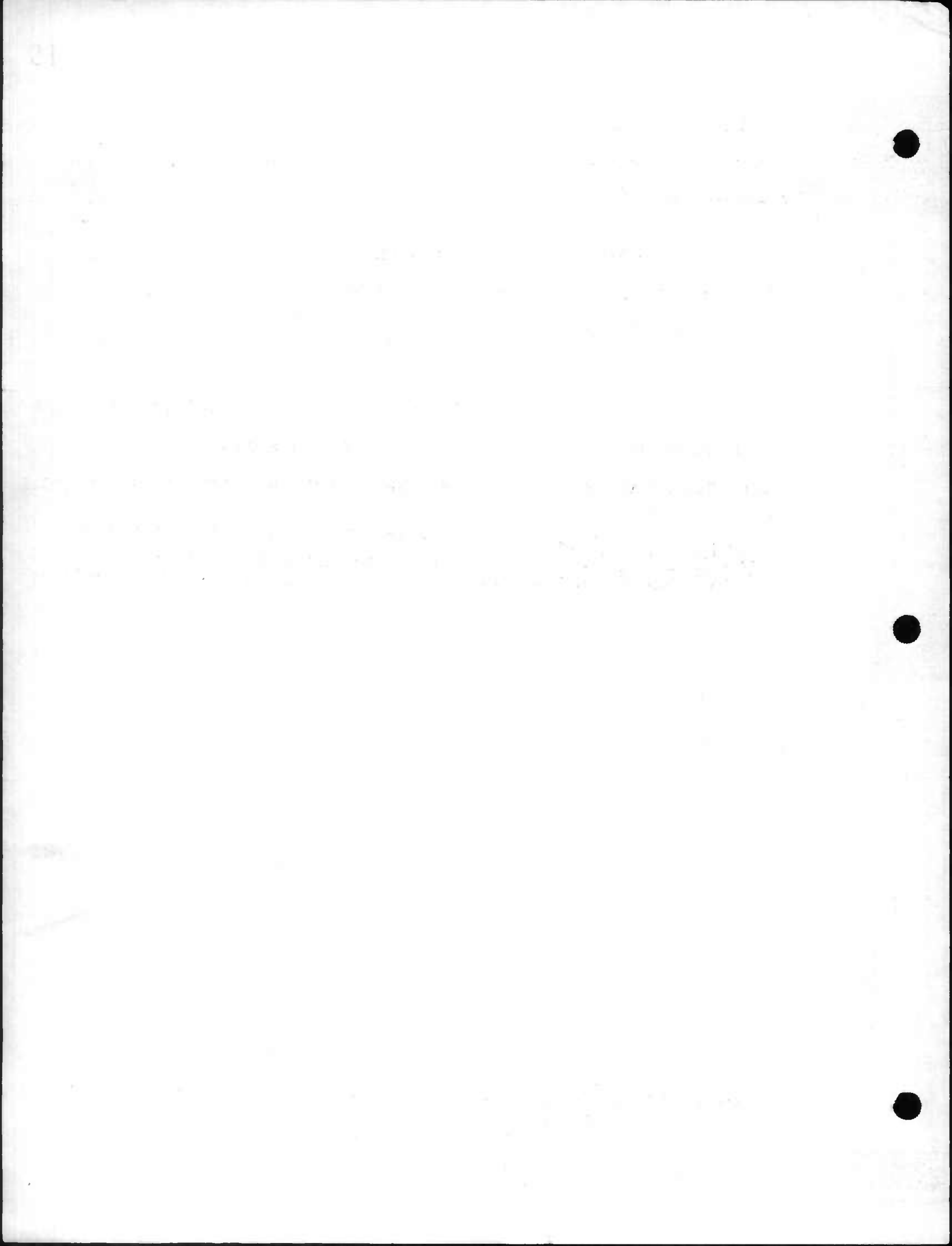
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRVING MILTON ZIMMERMAN</b>				2. Date of Death Month <b>MAY</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>7:15 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>062-03-8110</b> <b>124-03-1715</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/18/10</b>	9. Birthplace (State or Foreign Country) <b>NY, NY</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>CHEVY CHASE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>8100 CONNECTICUT AVE. #911</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>WW II</b> If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1</b>			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CAPTAIN</b>			16b. Kind of Business/Industry <b>UNITED STATES ARMY</b>			
	17. Father's Name (First, Middle, Last) <b>SIMON ZIMMERMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE ROTHMAN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>DORIS ZIMMERMAN/ WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8100 CONNECTICUT AVE. CHEVY CHASE, MD 20815</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEM 5/9</b>		Date <b>5/9</b>		20c. Location - City or Town, State <b>CHELTENHAM, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>IVES-PEARSON FUNERAL HOMES</b> <b>472 N. WASH. ST. FALLS CHURCH, VA. 22046</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RUPTURED AORTIC ANEURYSM</b> Due to (or as a consequence of): <b>ABDOMINAL AORTIC ANEURYSM</b> Due to (or as a consequence of): <b>VASCULAR HEART DISEASE</b> Due to (or as a consequence of): <b>SEPSIS</b> Due to (or as a consequence of): <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>RENAL FAILURE</b>								Approximate Interval Between Onset and Death <b>1 DAY</b> <b>YRS</b> <b>YRS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEPSIS</b> <b>RESPIRATORY FAILURE</b> <b>RENAL FAILURE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Dr. Steven J. Anderson</b>		29c. License number <b>D30112</b>		29d. Date signed (Month, Day, Year) <b>MAY 10/1996</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>VIREN DRA K. SAXENA, 7100 DEER CROSSING CT. BETHESDA MD 20817</b>										
31. Date filed (Month, Day, Year) <b>MAY 21 1996</b>		32. Registrar's Signature  <b>Julia Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 14920

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLADYS MILDRED AUSHERMAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>5</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-14-6219</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 6, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>424 GUILFORD AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HAGERSTOWN</b>		9c. COUNTY OF DEATH <b>WASHINGTON</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>WASHINGTON</b>		10c. CITY, TOWN OR LOCATION <b>HAGERSTOWN</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>424 GUILFORD AVENUE</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+) <b>CLERK</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STATIONERY STORE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LEMUEL H. CLINE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIE VIRGINIA SPIELMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WALTER LEE GREEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>424 GUILFORD AVENUE, HAGERSTOWN, MARYLAND 21740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BOONSBORO CEMETERY 5/8/96</b>		20c. LOCATION — City or Town, State <b>BOONSBORO, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul M. Dean</i> Paul M. Dean				22. NAME AND ADDRESS OF FACILITY <b>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardio-respiratory arrest / Asphyxia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>aging process</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>5-10 min</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>NA</i>		28b. TIME OF INJURY <i>NA</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify) <i>NA</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>NA</i>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Dean MD</i>				29c. LICENSE NUMBER <i>D46561</i>		29d. DATE SIGNED (Month, Day, Year) <i>5.7.96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Ghazala Oadir 11110 Medical Campus Drive, Hagerstown, MD 21742</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-14-83 BY SP-8 BJS/STW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14921

Amended # 11. P.G.C. 5-15-96 CR

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMANUEL AZIAMADO				2. Date of Death Month Day Year April 24 1996				3. Time of Death 1:46 AM		
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 226-65-1772		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) April 30, 1955		9. Birthplace (State or Foreign Country) TOGO, W. AFRICA		
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1401 Blair Mill Road #701		10f. Zip Code 20910		10g. Citizen of What Country? West Africa		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Room Attendant				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Room Attendant		16b. Kind of Business/Industry Private Industry				
	17. Father's Name (First, Middle, Last) Aziamado Yao				18. Mother's Name (First, Middle, Maiden Surname) Efua Kohoe						
	19a. Informant's Name/Relationship (Type, Print) Amegavi Adje, Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Mass. Ave., Washington, D. C. 20008						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cimetiere Keve		20c. Location - City or Town, State 18 May 96 Togo, West Africa						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Johnson & Jenkins Funeral Home Inc 716 Kennedy Street, N. W., Washington, D.C. 20011						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory depression</u> Due to (or as a consequence of): b. <u>Metastatic leiomyosarcoma</u> Due to (or as a consequence of): c. <u>Progressive liver dysfunction</u> Due to (or as a consequence of): d.										2 Hours 6 months 4 months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Gastric ulcer disease</u> <u>Sickle cell anemia trait</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D35996		29d. Date signed (Month, Day, Year) 04-24-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Dr #201, Silver Spring, MD 20902											
31. Date filed (Month, Day, Year) MAY 03 1996				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

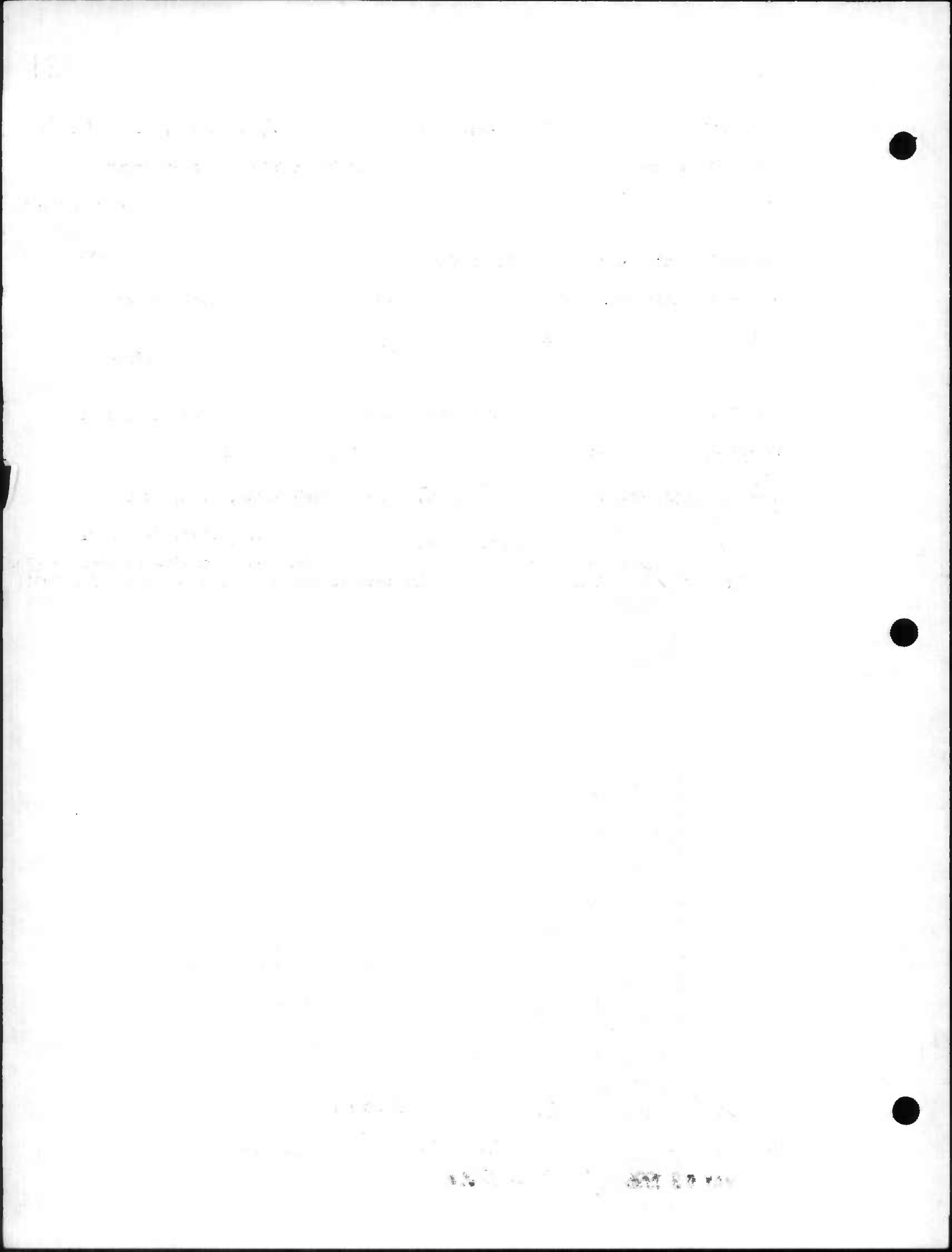
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





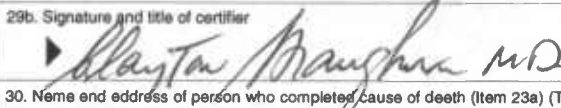
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14922

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Anastasi				2. Date of Death Month Day Year April 26, 1996				3. Time of Death 11:49 AM	
	4a. Facility Name (If not institution, give street and number) 8919 57th Avenue				4b. City, Town, or Location of Death Berwyn Heights				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-46-1638		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 26, 1936		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Berwyn Heights				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 8919 57th Avenue				10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-59		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry D.C. Recreation			
	17. Father's Name (First, Middle, Last) Angelo Anastasi				18. Mother's Name (First, Middle, Maiden Surname) Rocchina Chiccia Perro					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen Anastasi - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8919 57th Avenue, Berwyn Heights, Maryland 20740					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 04/30/96		20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. GERSTNANN STRAUSSLEN SCHEINKER SYNDROME 6 Months Due to (or as a consequence of): b. SPINOCELLULAR DEGENERATION Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  M.D.		29c. License number D45796		29d. Date signed (Month, Day, Year) 4/26/96	
	30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) Dr. Clayton Straughn, M.D. 6525 Belcrest Road, #150, Hyattsville, MD 20782									
	31. Date filed (Month, Day, Year) MAY 02 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120.

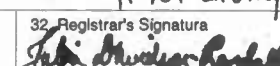
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14923

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |   |   |  |   |  |                                   |  |
|---|---|---|--|--|--|--|---|---|--|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD E. ACTON</b>                                 |   |  |  |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>28</b> Year <b>1996</b> |   | 3. Time of Death<br><b>8:25 AM</b>                   |   |  |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b> |   |  |  |  |  | 4b. City, Town, or Location of Death<br><b>CHINTON</b>                |   | 4c. County of Death<br><b>PRINCE GEORGE</b>          |   |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-14-7017</b>   |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. |  | If Under 1 Year<br>Months Days  |   | If Under 24 Hrs.<br>Hours Min.                       |   |  |                                   |  |
|   | 6. Date of Birth (Month, Day, Year)<br><b>3-19-15</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>        |  | 10a. State<br><b>Maryland</b>                    |  | 10b. County<br><b>Prince George's</b>                                 |   | 10c. City, Town or Location<br><b>Ft. Washington</b> |   |  |                                   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2516 Larry Ave.</b>   |  | 10f. Zip Code<br><b>20744</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>             |  |                                   |  |
| 16b. Kind of Business/Industry<br><b>Federal Government</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Henry Acton</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Williams</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy L. Corley/Stepdaughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6902 Burch Hill Rd. Brandywine, Maryland 20613</b>          |  |   |  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington Nat'l. Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>   |  |   |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC OBSTRUCTIVE Pulmonary disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>1 week</b>   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><b>William J. Tanner MD</b>  |  | 29c. License number<br><b>D 35206</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/29/96</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William T. TANNER MD 11701 Livingston Road, Fort Washington, MD.</b> |  |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>   |   | 32. Registrar's Signature<br>  |  |  |  |  |   |   |  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



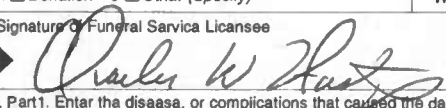
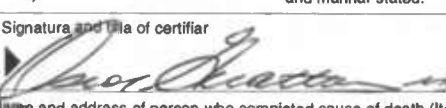
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14924

## Certificate of Death

Reg. No.

|   |  |  |   |                                |  |
|---|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ALFRED L. Adkins SR.</b>  |  | 2. Date of Death<br>Month <b>May</b> , Day <b>1</b> , Year <b>1996</b>  |                                | 3. Time of Death<br><b>2123</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |                                | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-10-0438</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 5, 1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |                                |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |   |                                |  |
|   | 10a. State<br><b>MARYLAND</b>  | 10b. County<br><b>WICOMICO</b>   | 10c. City, Town or Location<br><b>WILLARDS</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>7324 CANAL STREET</b>   |  | 10f. Zip Code<br><b>21874</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b>12</b>               |                                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CABLE SPICER</b>   |  | 16b. Kind of Business/Industry<br><b>TELEPHONE COMPANY</b>  |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HOMER L. ADKINS</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LAURA N. TRUITT</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>HAZEL P. ADKINS</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7324 CANAL STREET, WILLARDS, MARYLAND 21874</b> |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WILLARDS CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>5/5/96 WILLARDS, MARYLAND</b>  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</b>  |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                | Approximate Interval Between Onset and Death   |
|   | Immediata Causa (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):   |  |   |                                | <b>10Q</b>   |
|   | b. <b>Pulmonary Candidiasis</b><br>Due to (or as a consequence of):  |  |   |                                | <b>4Q</b>  |
|   | c. <b>Colon Carcinoma</b><br>Due to (or as a consequence of):  |  |   |                                | <b>74y</b>   |
| To Be Completed by Physician/Medical Examiner | Part ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i.<br><b>Renal Insufficiency, Severe Hypoalbuminemia</b><br><b>Iron deficiency Anemia</b>  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                |  |
|   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |
|   | 28d. Describe how injury occurred  |  |   |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |
|   | 29b. Signature and Title of certifier<br>   |  | 29c. License number<br><b>D 47619</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>5/2/96</b>   |
|   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Oscar M. Gualteros MD, 2627 Highman Rd. Salisbury MD 21804</b>  |  |   |                                |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>MAY 03 1996</b>  |  | 32. Registrar's Signature<br>                                    |                                |  |

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State of Maryland / Department of Health and Mental Hygiene

96 14925

## Certificate of Death

Reg. No.

|  |   |   |   |   |   |   |   |  |
|--|---|---|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Mary MADGLEN Butler</i>  |   |   |   | 2. Date of Death<br>Month <i>May</i> Day <i>9</i> Year <i>1996</i>  |   | 3. Time of Death<br><i>12:40p.m.</i>                                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>EASTON MEM Hospital</i>  |   |   |   | 4b. City, Town, or Location of Death<br><i>Easton</i>   |   | 4c. County of Death<br><i>TALBOT</i>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>218-20-3423</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>82</i> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><i>JANUARY 1, 1914</i> | 9. Birthplace (State or Foreign Country)<br><i>DORCHESTER</i>   |   |   |  |
|  | Usual Residence of Decedent   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
| To Be Completed by Funeral Director  | 10e. State<br><i>MARYLAND</i>   | 10b. County<br><i>DORCHESTER</i>  | 10c. City, Town or Location<br><i>CAMBRIDGE</i>   |   | 10f. Zip Code<br><i>21613</i>   |   |   |  |
|  | 10e. Street and Number<br><i>701 RACE STREET</i>  |   | 10g. Citizen of What Country?<br><i>USA</i>   |   | 10f. Zip Code<br><i>21613</i>   |   |   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Second <input checked="" type="checkbox"/> (10-12) College (1-4 or 5+) <i>NONE</i>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Domestic</i>                      |   | 16b. Kind of Business/Industry<br><i>HOME MAKER</i>   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>JAMES T BUTLER</i>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>GLENNIE CLARKSON</i>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>PAULINE YOUNG</i>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>701 RACE ST Cambridge Md. 21613</i>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>PATRESBURG CH CEMETERY</i>   |   | 20c. Date<br><i>MAY-9</i>   |   | 20d. Location - City or Town, State<br><i>Petersburg Md.</i>            |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Lewin H. Boardley</i>   |   |   |   | 22. Name and Address of Facility<br><i>BOARDLEY &amp; F/H 812 HILBARD-ST. CAMBRIDGE, MD 21613</i>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>cerebrovascular accident</i><br>Due to (or as a consequence of):<br>b. <i>urinary tract infection with sepsis.</i><br>Due to (or as a consequence of):<br>c. <i>adult onset diabetes mellitus</i><br>Due to (or as a consequence of):<br>d. <i>end stage renal disease</i> |   |   |   | Approximate Interval Between Onset and Death<br><br><i>1 day</i><br><i>3 days</i><br><i>&gt;10 years</i><br><i>1995</i>   |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>coronary artery disease</i><br><i>hypertension</i><br><i>peripheral vascular disease</i>   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                                      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |   |   |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 28e. Date of Injury (Month, Day Year)   |   |   |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>SODD</i>  |   | 29c. License number<br><i>D 46020</i>                         |   | 29d. Date signed (Month, Day, Year)<br><i>5/9/96</i>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>SYED I ALI MD 506 IDLE WILD AVE. EASTON 21601</i>   |   |   |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 13 1996</i>  |   | 32. Registrar's Signature<br><i>Julia Swinson-Randall</i>   |   |   |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14926

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Richard Rowland BONEBRAKE

2. Date of Death  
Month Day Year

May

4

1996

3. Time of Death

0550

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-09-5175

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 8, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

627 Chestnut Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

0

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

owner and operator

16b. Kind of Business/Industry

alignment shop

17. Father's Name (First, Middle, Last)

George Bonebrake

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Rowland

19a. Informant's Name/Relationship (Type, Print)

Dora M. Bonebrake

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 Chestnut Street, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Data

5-7-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIO PULMONARY FAILURE

Due to (or as a consequence of):

2 wks

b.

PULMONARY EMBOLISM.

Due to (or as a consequence of):

History

c.

ACUTE RENAL FAILURE

Due to (or as a consequence of):

History

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

ATRIO-VENTRICULAR BLOCK

BILATERAL CAROTID STENOSIS STATUS POST END-ARTERECTOMY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 47613

29d. Date signed (Month, Day, Year)

MAY 5<sup>th</sup> 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ahmed

11110 Medical Campus

Hager, Md. 21742

31. Date filed (Month, Day, Year)

MAY 06 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14927

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Irene B. Brooke                                      |   |  |  | 2. Date of Death<br>Month: May Day: 7 Year: 1996 |  | 3. Time of Death<br>9:50 AM                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Howard County General Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Columbia |  | 4c. County of Death<br>Howard                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-38-1362   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>54 Yrs.        |  | 8. Date of Birth (Month, Day, Year)<br>Nov 18, 1941 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10a. State<br>Maryland   |  | 10b. County<br>Howard                            |  | 10c. City, Town or Location<br>Columbia             |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>7312 Hidden Cove   |  | 10f. Zip Code<br>21046   |   | 10g. Citizen of What Country?<br>United States   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>James Rose  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Wilma Baker   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Claude L. Brooke/Husband   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>PO Box 15 Jessup, Maryland 20794  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Balt-Washington Crematory   |  | 20c. Date<br>5-8-96  |  | 20d. Location - City or Town, State<br>Laurel, Maryland                              |   |  |  |
| 21. Signature of Funeral Service Licensee<br>Harry H. Witzke   |  |   |  | 22. Name and Address of Facility<br>Harry H. Witzke Funeral Home, Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEVERE METABOLIC ACIDOSIS<br>Due to (or as a consequence of):<br>b. PROBABLE ISCHEMIC BOWEL DISEASE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br>1 DAY<br>1 DAY   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ALCOHOLISM, SEIZURE DISORDER, HEPATITIS, CIRRHOSIS   |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>J. Gibbons, MD   |  |  |  |  |   |  |  |
|  |  | 29c. License number<br>D38296   |  | 29d. Date signed (Month, Day, Year)<br>MAY 7, 1996   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042   |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 09 1996   |  | 32. Registrar's Signature<br>John Andrew Randall  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14928

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Ellen Bathgate</b>   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>3:15pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secours Extended Care Facility</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>   |  | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-48-3631</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 24, 1909</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>4319 Montgomery Road</b>   |  | 10f. Zip Code<br><b>21043</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Henry Laumann</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Effie May Murray</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ralph S. Bathgate/Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4319 Montgomery Road Ellicott City, MD 21043</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Johns Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>5-8-96 Ellicott City, MD</b>   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Shirley Collins-Witzke</b>   |   |   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Acute Renal Failure</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><br>5 days.<br><br>Years. |   |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic Cardio-vascular Disease</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>N/A.</b>  |   | 28b. Time of Injury<br><b>N/A. / M</b>           |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A.</b>   |   | 28b. Describe how injury occurred<br><b>N/A.</b> |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A.</b>  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>N. B. Vallanti</b>  |   | 29c. License number<br><b>D 30469.</b>           |  | 29d. Date signed (Month, Day, Year)<br><b>May, 7th, 1996.</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Vallanti<br/>9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042.</b>  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 09 1996</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14929

|   |  |   |                                 |  |   |  |  |   |
|---|--|---|---------------------------------|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>William W. Blair</u>                            |   |                                 |  | 2. Date of Death<br>Month <u>April</u> Day <u>28</u> Year <u>1996</u> |  | 3. Time of Death<br><u>10<sup>30</sup> pm</u>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Baltimore VA Hospital</u> |   |                                 |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>              |  | 4c. County of Death<br><u>Baltimore</u>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><u>174-18-8504</u>  |   | 6. Sex<br><u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday)<br><u>78</u> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>June 16, 1917</u>  | 9. Birthplace (State or Foreign Country)<br><u>Pennsylvania</u> |
|   | Usual Residence of Decedent  |   |                                 |  |   |  |  |   |
| 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>Baltimore</u>   |                                 | 10c. City, Town or Location<br><u>Woodlawn</u>   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><u>3239 North Rolling Road</u>  |  |   |                                 | 10f. Zip Code<br><u>21244</u>  |   | 10g. Citizen of What Country?<br><u>United States</u>  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>WWII</u>   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                            |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>   |  |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Custodian</u>  |   |  | 16b. Kind of Business/Industry<br><u>Church</u>  |   |
| 17. Father's Name (First, Middle, Last)<br><u>William W. Blair Jr.</u>  |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Sadie Wilson</u>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Mrs. Mary Ellen Blair</u>  |  |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3239 North Rolling Road Woodlawn, Maryland 21244</u>   |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Garrison Forest Veterans</u>   |                                 | Date<br><u>5-1-96</u>  |   | 20c. Location - City or Town, State<br><u>Owings Mills, MD</u>   |  |   |
| 21. Signature of Funeral Service Licensee<br><u>Shirley A. Collins-Witzke</u>   |  |   |                                 | 22. Name and Address of Facility<br><u>Harry H. Witzke Funeral Home, Inc.</u><br><u>4112 Old Columbia Pike Ellicott City, MD 21043</u>   |   |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cerebrovascular Accident</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                                 |  |   |  |  | Approximate Interval Between Onset and Death<br><u>23 days</u>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Alzheimer's Disease</u>  |  |   |                                 |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |   |                                 |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |                                 |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                 |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                 | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                               |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                 |  |   |  |  |   |
| 29b. Signature and title of certifier<br><u>James D. LeClair</u>  |  |   |                                 | 29c. License number<br><u>VA# 22-10039</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>4/28/96</u>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>James D. LeClair Baltimore VA Hospital Baltimore, Maryland</u>   |  |   |                                 |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><u>APR 30 1996</u>   |  | 32. Registrar's Signature<br><u>John Davidson Randall</u>   |                                 |  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is devoted to a general survey of the situation in the country. It is a very interesting and useful survey, and it is well worth reading. It gives a very good idea of the general state of the country, and of the progress of the various departments of the government.

2. The second part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

3. The third part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

4. The fourth part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

5. The fifth part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

6. The sixth part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

7. The seventh part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

8. The eighth part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.

9. The ninth part of the report is devoted to a detailed account of the various departments of the government. It is a very interesting and useful account, and it is well worth reading. It gives a very good idea of the progress of the various departments of the government, and of the state of the country.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14930

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |   |  |                                   |   |  |
|---|---|--|---|---|--|--|--|---|--|-----------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARTHA BENNETT</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 26, 1996</b>  |  |  |   | 3. Time of Death<br><b>1040 AM</b>   |                                   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |  |   | 4c. County of Death<br><b>BALTIMORE</b>  |                                   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>223-26-3777</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>January 26, 1923</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |                                   |   |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |   |  |                                   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George</b>   |   | 10c. City, Town or Location<br><b>Beltsville</b>   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                   |   |  |
|   | 10e. Street and Number<br><b>11907 Beltsville Drive</b>   |  |   |   | 10f. Zip Code<br><b>20705</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                    |   |  |                                   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |                                   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fountain Manager</b>   |  |  | 16b. Kind of Business/Industry<br><b>Food Service</b>   |  |                                   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Emmett Farley</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Perry</b>   |  |  |   |  |                                   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donald E. Bennett, Sr. spouse</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11907 Beltsville Drive, Beltsville, Maryland 20705</b>                                       |  |  |   |  |                                   |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | Date<br><b>4/27/96</b>   |   | 20c. Location - City or Town, State<br><b>Catonsville, Maryland</b>  |                                   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>   |  |  |   |  |                                   |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ischemic Cardiomyopathy</b><br>Due to (or as a consequence of):<br>b. <b>Ruptured Aneurysm</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |   |  |                                   | Approximate Interval Between Onset and Death<br><b>3 months</b> |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |                                   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |  |  |   |  |                                   |   |  |
| 29b. Signature and title of certifier<br> M.D.   |   |  |   | 29c. License number<br><b>9677</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 26, 1996</b> |  |   |  |                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joydeep Som 22 S. Greene Street Baltimore, MD 21201</b>  |   |  |   |   |  |  |  |   |  |                                   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |   |  |   | 32. Registrar's Signature<br>  |  |  |  |   |  |                                   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

96 14931

## Certificate of Death

Reg. No.

|                                     |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Veta Viola Brown   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 23 1996  |  | 3. Time of Death<br>8:36 pm  |  |
|                                     | 4e. Facility Name (If not institution, give street and number)<br>WASHINGTON ADVENTIST HOSPITAL  |  |  |  | 4b. City, Town, or Location of Death<br>TAKOMA PARK  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                 | 5. Social Security Number<br>577 78 4097   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>66 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>July 24, 1929   |  |
|                                     | 9. Birthplace (State or Foreign Country)<br>JAMAICA  |  | 10e. State<br>MARYLAND   |  | 10b. County<br>PRINCE GEORGES  |  | 10c. City, Town or Location<br>ADELPHI   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10f. Zip Code<br>20783   |  | 10g. Citizen of What Country?<br>JAMAICA   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
|                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)  |  |
|                                     | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>COMPANION  |  | 16b. Kind of Business/Industry<br>HEALTH CARE  |  | 17. Father's Name (First, Middle, Last)<br>HENRY WALCOTT   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELSIE PLUMMER   |  |
|                                     | 19. Informant's Name/Relationship (Type, Print)<br>ROSE MARIE BROWN  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS 10e   |  | 20. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLENWOOD CEMETERY APRIL 29, 1996 WASHINGTON, DC  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>TAKOMA FUNERAL HOME INC 254 CARROLL ST. N.W. WASHINGTON, D.C. 20012  |  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. MASSIVE CEREBROVASCULAR ACCIDENT<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br>5 days   |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                                     | 26. Piece of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D-17874   |  | 29d. Date signed (Month, Day, Year)<br>4-24-96   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SANKARAN M. NAYAR, MD. 3717-38th AVE, COTTAGE CITY, MD 20722   |  | 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  | 32. Registrar's Signature<br>   |  | State Registrar  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 14932

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Indiana Burke  |   |  |   | 2. Date of Death<br>Month Day Year<br>April 19, 1996 |  |   |  | 3. Time of Death<br>8:40 PM                            |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Allegis Healthcare & Rehab. Center |   |  |   | 4b. City, Town, or Location of Death<br>Bethesda     |  |   |  | 4c. County of Death<br>Montgomery                      |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-42-1615   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>90 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 11, 1905 |  | 9. Birthplace (State or Foreign Country)<br>Albany, GA |  |  |
|   | Usual Residence of Decedent  |   |  |   |  |  |   |  |  |  |  |
| 10a. State<br>DC  |  | 10b. County   |  | 10c. City, Town or Location<br>Washington   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>4103 New Hampshire Ave. N.W.  |  |   |  | 10f. Zip Code<br>20011  |  |  |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                 |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6th<br>College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dressmaker   |  |  |   | 16b. Kind of Business/Industry<br>Self Employed  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Edward Buford  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Buford   |  |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Josie B. Smith  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10200 Buena Vista Ave. Lanham, MD 20706  |  |  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National  |  | Data<br>5-6-96  |  | 20c. Location - City or Town, State<br>Arlington, Virginia |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>J. P. Marshall   |  |   |  | 22. Name and Address of Facility<br>Marshall's Funeral Home, Inc.<br>4217 9th Street N.W., Wash., DC 20011  |  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Sepsis<br>Dua to (or as a consequence of):<br>b. Pneumonia<br>Dua to (or as a consequence of):<br>c.<br>Dua to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>days   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                                   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br>Joel R. Schulman   |  |  |   | 29c. License number<br>D20516  |  | 29d. Date signed (Month, Day, Year)<br>April 24, 1996  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joel R. Schulman, M.D., FCCP 9410 Old Georgetown Rd., Bethesda, Maryland 20814  |  |   |  |   |  |  |   |  |  |  |  |
| 31. Date signed (Month, Day, Year)<br>APR 29 1996   |  |   |  | 32. Registrar's Signature<br>John A. ...  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14933

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN BLOCKER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 20, 1996</b>   |  | 3. TIME OF DEATH<br><b>7:20 A.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>052-26-7994</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 22, 1933</b>                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>  |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>8216 CANNING TERRACE</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GREENBELT</b>   |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                                    |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>PRINCE GEORGE'S</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>GREENBELT</b>                                  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>8216 CANNING TERRACE</b>  |  |  |  | 10f. ZIP CODE<br><b>20770</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                            |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KOREAN WAR</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MAINTENANCE SUPERVISOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TRANSPORTATION</b>                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHNNY B. BLOCKER, SR.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GERALDINE A. SPAIGHTS</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GWENDOLYN GREEN-BLOCKER, WIFE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8216 CANNING TERRACE, GREENBELT, MARYLAND 20770</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CEMETERY 4/24/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>BRENTWOOD, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rein Buttery</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FORT LINCOLN FUNERAL HOME, INC.<br/>3401 BLADENSBURG RD., BRENTWOOD, MD 20722</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. <b>CARCINOMA OF ESOPHAGUS</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>METASTASIS OF LIVER</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>CORONARY ARTERY DISEASE</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d. <b></b>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W Singh</i> <i>Attend Phys</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19897</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 20, 1996</b>                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VIRENDER P. SINGH, M.D., 7209-A HANOVER PARKWAY, GREENBELT, MARYLAND 20770</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

March 10 1912



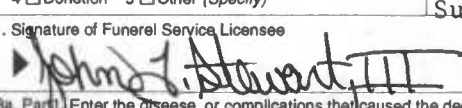
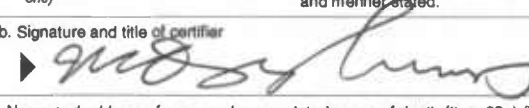
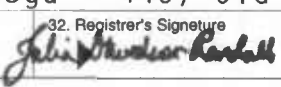
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14934

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |  |
|--|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LENNIE BARRON</b>   |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 21, 1996</b>                                 |  | 3. Time of Death<br><b>11:30am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fort Washington Hospital</b>  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>                              |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>263-01-6829</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 6. Date of Birth (Month, Day, Year)<br><b>October 12, 1912</b>       |  | 9. Birthplace (State or Foreign Country)<br><b>Chester, GA</b>   |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Florida</b>   |   | 10b. County<br><b>Volusia</b>   |  | 10c. City, Town or Location<br><b>Daytona Beach</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>1432 Illinois Street</b>  |   |   |  | 10f. Zip Code<br><b>32114</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>                |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5 years</b> College (1-4 or 5+)  |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |   |  | 16b. Kind of Business/Industry<br><b>private</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Arlene Allen</b>   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>                         |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillie Bell - Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1712 Dauphin Drive; Fort Washington, MD 20744</b>  |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |  | Date<br><b>4/26/96</b>   |   | 20c. Location - City or Town, State<br><b>Daytona Beach, Florida</b> |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc.<br/>4001 Benning Road, N.E. Washington, D.C.</b>   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebral Vascular Accident</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia, CHF</b><br><b>Rheumatoid Arthritis, Anemia</b>   |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |  | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D37066</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 21, 1996</b>                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Uchechi Opaigbeogu 4467 Old Branch Ave. #105 Temple Hills, MD 20748</b>   |  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14935

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Harold E. Brown  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 18, 1996  |  | 3. TIME OF DEATH<br>8:41p. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>230-36-0621   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 7, 1930   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Waynesboro, Virginia   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Prince George's Medical Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cheverly  |  |
| 9c. COUNTY OF DEATH<br>Prince George's Co.   |  |  |  | 10a. STATE<br>Virginia  |  | 10b. COUNTY<br>Augusta   |  |
| 10c. CITY, TOWN OR LOCATION<br>Waynesboro  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>240 Shilah Avenue  |  |
| 10f. ZIP CODE<br>22980   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States of America   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean Conflict  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Warehouseman  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dupont Textile Manufacturing   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wilmer A. Brown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alise V. Watkins   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Gloria Brown Odom  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20772<br>57 Harry S. Truman Drive #34, Largo, Maryland   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fairview Cemetery 4/23/1996  |  | 20c. LOCATION — City or Town, State<br>Waynesboro, Virginia  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>#MO0690<br>Howard A. Cason  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>McCutcheon's Funeral Home 22980<br>267 Port Republic Road, Waynesboro, VA   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>a <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Augusto P. Rodriguez  |  |  |  | 29c. LICENSE NUMBER<br>D21230   |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 19, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 30 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>J. A. Hudson-Rodriguez   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14936

## Certificate of Death

Reg. No.

|  |   |   |   |  |   |  |  |                                   |  |
|--|---|---|---|--|---|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Dorothy Virginia Brittain   |   |   |  | 2. Date of Death<br>Month Day Year<br>April 17, 1996  |  | 3. Time of Death<br>5:21 A.M.                                    |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Shady Grove Adventist Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Rockville   |  | 4c. County of Death<br>Montgomery County                         |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-05-5678  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>83 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>September 14, 1912  | 9. Birthplace (State or Foreign Country)<br>Virginia  |  |  |                                   |  |
|  | Usual Residence of Decedent   |   |   |  |   |  |  |                                   |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  | 10b. County<br>Frederick County   | 10c. City, Town or Location<br>Ijamsville   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |                                   |  |
|  | 10e. Street and Number<br>2735 Loch Haven Drive   |   |   | 10f. Zip Code<br>21754   |   | 10g. Citizen of What Country?<br>United States of America                            |  |                                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Purchasing Agent                      |   | 18b. Kind of Business/Industry<br>Stationery Supply                                  |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles Euclid Johnson   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie Virginia Johnson  |  |  |                                   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Virginia Long (Daughter)  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2735 Loch Haven Drive, Ijamsville, Maryland 21754 |   |  |  |                                   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fairview Cemetery   |  | Date<br>4/21/96   |  | 20c. Location - City or Town, State<br>Culpeper, Virginia        |                                   |  |
|  | 21. Signature of Funeral Service Licensee #M00690<br>Howard A. Carson   |   |   | 22. Name and Address of Facility<br>Clore Funeral Home, Inc.<br>P.O. Box 100, Culpeper, Virginia   |   |  |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |                                   | Approximate Interval Between Onset and Death<br>3 Years<br>5 Years   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Pulmonary Disease<br>Diabetes Mellitus  |   |   |  |   |  |  |                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Carl I. Schoenberger M.D.  |   | 29c. License number<br>D 26540   |   | 29d. Date signed (Month, Day, Year)<br>APRIL 26, 1996                                |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Carl I. Schoenberger, M.D. 16220 Frederick Road, Gaithersburg, MD  |   |   |   |  |   |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 1996   |   | 32. Registrar's Signature<br>John [Signature]   |   |  |   |  |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



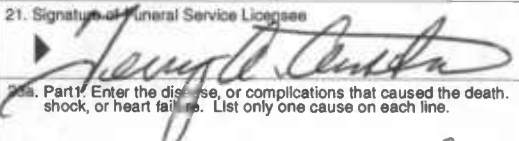

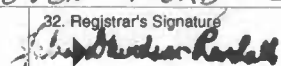
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14937

## Certificate of Death

Reg. No.

|  |  |  |                                  |   |   |   |   |   |
|--|--|--|----------------------------------|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HOWARD BROWN</b>                                  |  |                                  |   | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> Year <b>1996</b> |   | 3. Time of Death<br><b>7:25AM</b>                       |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital</b> |  |                                  |   | 4b. City, Town, or Location of Death<br><b>Cheverly</b>               |   | 4c. County of Death<br><b>Prince Georges</b>            |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>231-26-4109</b>  |  | 6. Sex<br><b>10</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>2/23/1930</b> | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |
|  | Usual Residence of Decedent  |  |                                  |   |   |   |   |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Dorchester</b>   |                                  | 10c. City, Town or Location<br><b>Salisbury</b>   |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |   |
| 10e. Street and Number<br><b>1253 Middle Neck Drive</b>  |  |  |                                  | 10f. Zip Code<br><b>21801</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |  |  |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal Clerk, Supervisor</b>      |   | 16b. Kind of Business/Industry<br><b>Postal Service</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Brown Sr.</b>   |  |  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daisy Thornton</b>  |   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet P. Brown</b>  |  |  |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15833 Piller Lane, Bowie Md. 20716</b>        |   |   |   |   |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Roosevelt Cemetery</b>  |                                  | Data<br><b>4/27/96</b>  |   | 20c. Location - City or Town, State<br><b>Chesapeake, Virginia</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>  |  |  |                                  | 22. Name and Address of Facility<br><b>Austin Royster Funeral Home<br/>3605 14th St. N.W., Wash, D.C. 20010</b>                                   |   |   |   |   |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Severe hypoxia</b><br>Due to (or as a consequence of):<br>b. <b>Bilateral pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Melastake lung carcinoma</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Severe esophagitis most likely 2° to radiation</b> |  |  |                                  |   |   |   |   | Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>days</b><br><b>approx. 2 yrs</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Pleural effusion, Anaemia</b><br><b>Severe esophagitis most likely 2° to radiation</b>  |  |  |                                  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |                                  |   |   |   |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                  |   |   |   |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |                                  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |                                  | 29c. License number<br><b>D 24270</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/24/96</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. RAVINDER K. RUSTAGI<br/>6132 LANOOVER ROAD CHEVERLY, MD 20785</b>   |  |  |                                  |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 1996</b>  |  | 32. Registrar's Signature<br>   |                                  |   |   |   |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9688.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

MASSACHUSETTS

NOTES

RECORDS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14938

## Certificate of Death

Reg. No.

|   |   |  |  |   |   |   |   |  |
|---|---|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>VERONICA RENEE BANKS                                |  |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 25 1996 |   | 3. Time of Death<br>20:22 PM                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGE HOSPITAL CENTER |  |  |   | 4b. City, Town, or Location of Death<br>Cheverly    |   | 4c. County of Death<br>PRINCE GEORGES             |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-88-7090  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>22 Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br>10-01-1973 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Washington, DC                                      |  | 10. Usual Residence of Decedent<br>10a. State<br>Maryland                      |   | 10b. County<br>Prince George's                      |   | 10c. City, Town or Location<br>Landover           |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 10e. Street and Number<br>1115 Nalley Road, Apt. #512  |  | 10f. Zip Code<br>20785  |   | 10g. Citizen of What Country?<br>U.S.A.   |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                 |  | 16b. Kind of Business/Industry<br>Private   |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Charles McNorial   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Irene Davis  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Irene Banks/Mother  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1418 Downing Street, NE, #4, Washington, DC 20018  |   |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Harmony Memorial Park  |  | 20c. Location - City or Town, State<br>Landover, Maryland   |   | 20d. Date<br>04/30 1996   |   |  |
| 21. Signature of Funeral Service Licensee<br>Nancy A. Perente   |   |  |  | 22. Name and Address of Facility<br>J. B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Stab wound of chest</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |  |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |   |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br>4-25-96  |  | 28b. Time of Injury<br>1920 M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred<br>Subject stabbed  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>home   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1103 Nalley Road<br>Landover, Prince George's MD  |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  | 29b. Signature and title of certifier<br>Donald G. Wright MD  |   | 29c. License number<br>O.C.M.E.   |   |  |
| 29d. Date signed (Month, Day, Year)<br>APRIL 26, 1996   |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 |  | 31. Date filed (Month, Day, Year)<br>MAY 01 1996  |   | 32. Registrar's Signature<br>J. B. Jenkins  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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96 14939

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Willie Banks Breeze  |  |  |  | 2. DATE OF DEATH<br>MONTH 04 DAY 27 YEAR 96   |  | 3. TIME OF DEATH<br>8:00 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>240-03-9136   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>02-02-07  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Laurel Regional Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Laurel   |  | 9c. COUNTY OF DEATH<br>Prince George's   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>Largo  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO    |  |
| 10e. STREET AND NUMBER<br>9805 Lakepoint Court #104  |  |  |  | 10f. ZIP CODE<br>20774  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3rd<br>College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Master Electrician  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Government   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sam Breeze  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Callie Vinson  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Evelyn Breeze/Wife   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9805 Lakepoint Court #104, Largo, MD 20774   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Harmony Memorial Park 5/2/96  |  | 20c. LOCATION — City or Town, State<br>Landover, MD   |  | 22. NAME AND ADDRESS OF FACILITY<br>J. B. Jenkins Funeral Home<br>7474 Landover Rd, Landover, MD 20785 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCT  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC RENAL FAILURE, DIABETES<br>METASTATIC PROSTATE CANCER, HYPERTENSION<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                   |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D 24997  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/27/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>LUIS A. CASAS MD. 8317 CHERRY LANE LAUREL MD. 20707   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAY 01 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



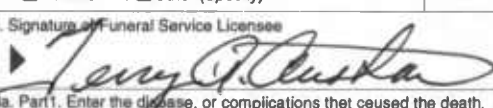


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14940

|   |  |   |   |   |  |  |  |  |                                   |  |
|---|--|---|---|---|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIS BOWERS</b>                                       |   |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1996</b>   |  | 3. Time of Death<br><b>1:30 P.M.</b>   |  |                                   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>1300 SOUTHVIEW DRIVE APT. 302</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>OXON HILL</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                                     |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>227-72-6789</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1952</b>                        | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |                                   |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |                                   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince Georges</b>  |   | 10c. City, Town or Location<br><b>Oxon Hill</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |                                   |  |
| 10e. Street and Number<br><b>1300 Southview Dr. #302</b>  |  |   |   | 10f. Zip Code<br><b>20745</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Worker</b>  |  | 16b. Kind of Business/Industry<br><b>District Of Columbia School</b>   |  |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Twisy Bowers</b>  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Adel Bowers</b>  |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Adel Bowers</b>  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1310 S. Street S.E., Wash, DC. 20020</b> |  |  |  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial</b>   |   | Date<br><b>4/30/96</b>   |  | 20c. Location - City or Town, State<br><b>Landover, MD</b>                       |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   |   | 22. Name and Address of Facility<br><b>Austin Royster Funeral Home<br/>3605 14th St. N.W. Wash, DC. 20010</b>                                |  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Intracerebral Hemorrhage</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |   |  |  |  | Approximate Interval Between Onset and Death   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |                                   |  |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |                                   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   | 29b. Signature and title of certifier<br><br><b>Theodore M. King</b>   |   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1996</b>   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEODORE M. KING</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |   |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 1996</b>   |  |   | 32. Registrar's Signature<br>  |   |  |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 14941

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jacqueline Devine Baynes</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28 96</b>  |  | 3. TIME OF DEATH<br><b>1140 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>112-52-8490</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>35</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 3, 1961</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Deaton Specialty Hospital &amp; Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |   |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>DC</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1225 Fairmont Street N.W., #102</b>   |  |  |  | 10f. ZIP CODE<br><b>20009</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nursing Aid</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Howard University Hospital</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Wellington Devine</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dollie Mae Devine</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Glen D. Baynes</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1225 Fairmont St. N.W. #102, Wash., DC 20009</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>  |  | 20c. DATE<br><b>5-2</b>   |  | 20d. LOCATION — City or Town, State<br><b>Washington, DC</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. P. Marshall</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th St. N.W., Washington, DC 20011</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>TOXOPLASMOSIS OF BRAIN</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>9 YRS</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Brian C. Wallace MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D31136</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 29, 1996</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BRIAN C. WALLACE MD, 611 S. CHARLES ST. BALTIMORE, MD 21230</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 02 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Rodell</b>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 2

12 11 10 9 8 7 6 5 4 3 2 1

1000000000

1000000000 1000000000 1000000000



Certificate of Death

Reg. No.

|   |  |  |   |  |   |                                 |   |  |  |   |  |                                       |  |  |  |
|---|--|--|---|--|---|---------------------------------|---|--|--|---|--|---------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GERTRUDE BROADUS</b>  |  |   |  |   |                                 | 2. Date of Death<br>Month Day Year<br><b>APRIL 27, 1996</b>   |  | 3. Time of Death<br><b>10:58 AM</b>  |   |  |                                       |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Larkin Chase Nursing Home</b>   |  |   |  |   |                                 | 4b. City, Town, or Location of Death<br><b>Bowie</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |   |  |                                       |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-48-3251</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>101</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>May 22, 1894</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |   |  |                                       |  |  |  |
|   | Usual Residence of Decedent  |  |   |  |   |                                 |   |  |  |   |  |                                       |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Clinton</b>   |                                 |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |                                       |  |  |  |
|   | 10e. Street and Number<br><b>7520 Surratts Road</b>  |  |   |  | 10f. Zip Code<br><b>20735</b>   |                                 | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |  |                                       |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |   |  |                                       |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Beautician</b>  |                                 |   | 16b. Kind of Business/Industry<br><b>Beauty Shop</b>                                 |  |   |  |                                       |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Henry Albert ABBOTT</b>  |  |   |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH CATHERINE RUCKER</b><br><del>Catherine Rucker</del> |  |  |   |  |                                       |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Grace Brown (Niece)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12720 Martin Rd.; Brandywine, Md. 20613</b>   |                                 |   |  |  |   |  |                                       |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery</b>   |                                 | Date<br><b>May 1, 1996</b>  |  | 20c. Location - City or Town, State<br><b>Landover, Md.</b>  |   |  |                                       |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Ralph Williams Funeral Service</b><br><b>517 - 11th St., SE; Wash., DC</b>   |                                 |   |  |  |   |  |                                       |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c. <b>SENILITY</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |                                 |   |  |  |   | Approximate Interval Between Onset and Death   |                                       |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHF</b>   |  |   |  |   |                                 |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                       |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |                                 |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                       |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |                                 |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                       |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |   | 28a. Date of Injury (Month, Day, Year)                                       |   | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |                                       |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                 |   |  |  |   |  |                                       |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |                                 |   |  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D-34525</b> |  | 29d. Date signed (Month, Day, Year)<br><b>04-29-96</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S-J Rao, MD-4000 Nutfieldville Road; #220; Bowie MD 20716</b>  |  |  |   |  |   |                                 |   |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |  | 32. Registrar's Signature<br>         |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14943

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BABY GIRL BENNETT (Reanna Macaria Bennett)</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 23, 1996</b>  |  | 3. Time of Death<br><b>12:15 P</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>N/A</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br><b>1 28</b>   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 25, 1996</b>   | 9. Birthplace (State or Foreign Country)<br><b>CHEVERLY, MD</b>  |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  | 10b. County<br><b>PRINCE GEORGES</b>                                       | 10c. City, Town or Location<br><b>FORESTVILLE</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>8006 BOUNDARY DRIVE</b>   |  |   | 10f. Zip Code<br><b>20747</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |   | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>REGINALD M. HILL</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DAWN BENNETT</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DAWN BENNETT / MOTHER</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8006 BOUNDARY DRIVE FORESTVILLE, MD 20747</b> |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK</b>  |   | 20c. Location - City or Town, State<br><b>4/27/96 LANOVER, MD</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Alex S Pope Jr</b>   |  |   | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 MARLBORO PIKE FORESTVILLE, MD 20747</b>                           |  |  |  |
|   | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Extreme Prematurity</b><br>Due to (or as a consequence of):<br><br>b. <b>Necrotizing Enterocolitis</b><br>Due to (or as a consequence of):<br><br>c. <b>Bowel Obstruction</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><b>2 months</b><br><b>1 WK</b><br><b>1 WK</b> |  |   |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Same as above</b><br><b>Chronic lung disease</b>  |  |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M <input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Green J. Lawrence</b>  |  | 29c. License number<br><b>036638</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 23, 1996</b>   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ESTELLE GAULT JOHN HOPKINS HOSPITAL, 600 N Wolfe St. Baltimore, Md.</b>   |  |   |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAY 2 1996</b>   |  | 32. Registrar's Signature<br><b>John A. Raskin</b>  |   |  |  |  |

2 1/1

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 14944

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GRACE P. BROWN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 20 1996</b>  |  | 3. TIME OF DEATH<br><b>10:20 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>325-10-1473</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 26, 1908</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY CO.</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY CO.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>10010 STEDWICK RD.</b>  |  |  |  | 10f. ZIP CODE<br><b>20879</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>TEACHER</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TEACHER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>EDUCATION</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRED FRANK BARKER</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HARRIET SIDDENS</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REV. DR. REICHARD</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9701- VEIRS DR., ROCKVILLE, MD. 20850</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY-4/21-ALEXANDRIA, VA.</b>  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. M. Hysong</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HYSONG CO. FUNERAL HOME<br/>1300- N STREET, NW, WASH., DC</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Alzheimer's Disease</b>  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>10 yr</b> |
|  |  | b. <b>Multi infarct dementia</b>   |  |   |  |   | <b>20 yr</b>   |
|  |  | c. <b>Major Depression</b>   |  |   |  |   | <b>30 yr</b>   |
|  |  | d.   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism, major Depression, Hypertension</b>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. Schemm M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 36618</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 20, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. C. SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD. 20850</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14945

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>HELEN E. BRITTINGHAM   |  |   |  | 2. Date of Death<br>Month <u>4</u> Day <u>30</u> Year <u>96</u>  |  | 3. Time of Death<br><u>10:05 AM</u>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>ATLANTIC GENERAL HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>BERLIN   |  | 4c. County of Death<br>WORCESTER   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>222-28-4779   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>11/20/10  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>DELAWARE  |  | 10b. County<br>SUSSEX  |  | 10c. City, Town or Location<br>DAGSBORO  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>R. D. # 1 BOX 201   |  | 10f. Zip Code<br>19939   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u>3</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  | 16b. Kind of Business/Industry<br>NONE   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>HARRY M. MURRAY   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LIZZIE E. HUDSON  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>REGINALD BRITTINGHAM-SON   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>36 MILL LANDING, MILLSBORO, DE. 19966   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CAREY'S CEMETERY  |  | 20c. Date<br>5/3/96  |  | 20d. Location - City or Town, State<br>FRANKFORD, DELAWARE   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>MELSON FUNERAL SERVICES, LTD.<br>FRANKFORD, DELAWARE   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br>a. <u>myocardial infarction</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><u>3 hours</u> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br> physician   |  |   |  | 29c. License number<br>H44283  |  | 29d. Date signed (Month, Day, Year)<br>4/30/96   |  |
|   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>ROBERT DURKIN<br>9733 Heathway Drive Berlin, MD  |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>MAY 02 1996   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

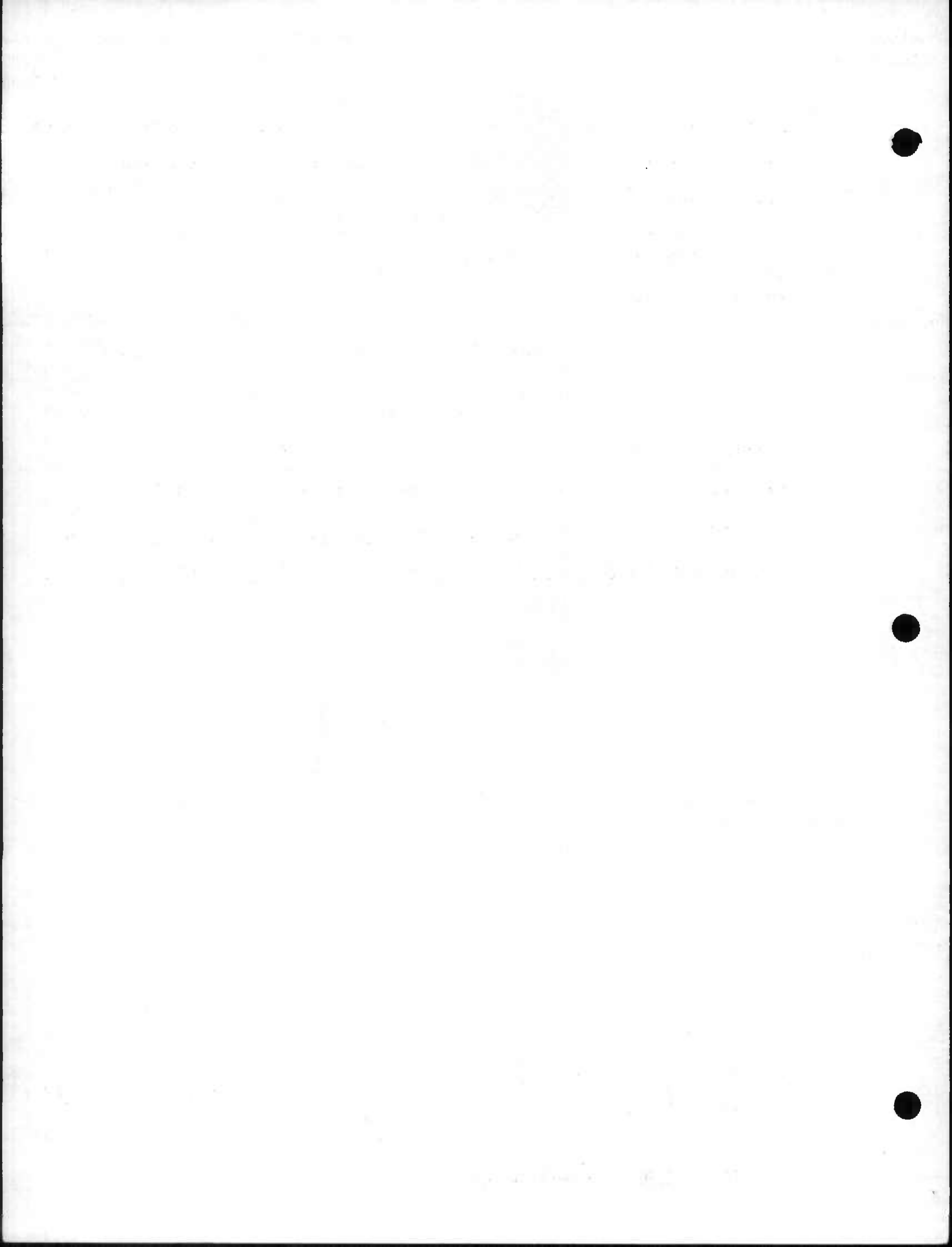
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 14946

Reg. No.

|  |   |                             |  |   |   |  |  |  |
|--|---|-----------------------------|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Paul F. Braun   |                             |  |   | 2. Date of Death<br>Month Day Year<br>April 27 1996   |  | 3. Time of Death<br>5:55pm   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>783 Harmony Ave.  |                             |  |   | 4b. City, Town, or Location of Death<br>Arnold  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-22-2980  |                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>69 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth (Month, Day, Year)<br>6-2-1926  | 9. Birthplace (State or Foreign Country)<br>MD |
|  | Usual Residence of Decedent   |                             |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  | 10b. County<br>Anne Arundel |  | 10c. City, Town or Location<br>Arnold     |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>783 Harmony Ave.  |                             |  |   | 10f. Zip Code<br>21012  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12   |                             |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Meat Cutter  |  | 16b. Kind of Business/Industry<br>US Naval Academy   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Martin Braun   |                             |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pauline  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Braun  |                             |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>783 Harmony Ave. Arnold, MD 21012  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MD Veterans Cemetery   |   | Date<br>5/1   | 20c. Location - City or Town, State<br>Crownsville, MD |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |                             |  |   | 22. Name and Address of Facility<br>Barranco & Sons Funeral Home<br>495 Ritchie Hwy Severna Park, MD 21146  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Congestive Heart Failure<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |                             |  |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |                             |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                             |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                             |  |   |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                             |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |                             | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                             |  |   | 28d. Describe how injury occurred   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                             |  |   |   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                             |  |   |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |                             |  |   | 29c. License number<br>1038445  |  | 29d. Date signed (Month, Day, Year)<br>May 5, 1996   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>L. Weinstern 600 Ridgely Ave Suite 121, Annapolis, MD   |                             |  |   |   |  |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020   | 31. Date filed (Month, Day, Year)<br>MAY 09 1996  |                             | Registrar's Signature<br><i>[Signature]</i>  |   |   |  |  |  |
|  |   |                             |  |   |   |  |  |  |



96 14947

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS BURNS BOLAND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>5</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>11:52 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-24-6830</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6-26-1928</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>AAMC</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>   |  | 9c. COUNTY OF DEATH<br><b>A.A.</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>A.A.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Severna Park</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>736 OAK Grove Circle</b>  |  |  |  | 10f. ZIP CODE<br><b>21146</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Splicer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Telephone</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick Boland</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Wiencke</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Fred Boland, III</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>737 OAK GROVE CIRCLE Severna Park, MD 21146</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan 5-8-96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert S. [Signature]</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Barranco and Sons Funeral Home<br/>495 Ritchie Hwy. Severna Park, MD 21146</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEVEN BULLER 900 Bostwick Road, Suite 300, Annapolis, MD 21401</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>H36078</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5/6/96</b>  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 09 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14948

## Certificate of Death

Reg. No.

|   |   |  |   |                                |   |  |  |  |
|---|---|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ralph Kenneth Beers   |  |   |                                | 2. Date of Death<br>Month Day Year<br>May 7 1996  |  | 3. Time of Death<br>4:30PM   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Chesapeake Health Care Center   |  |   |                                | 4b. City, Town, or Location of Death<br>Arnold  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>191-07-5298  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>90 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>October 8 1905  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|   | Usual Residence of Decedent   |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>PA  | 10b. County<br>Armstrong   | 10c. City, Town or Location<br>Apollo   |                                |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>Route 56 East Box 1010  |  |   | 10f. Zip Code<br>15613         |   | 10g. Citizen of What Country?<br>United States   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner/Operator   |                                |   | 16b. Kind of Business/Industry<br>Produce/Food   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Beers  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Rupert   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Bonita Blanchard/Granddaughter  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1621 Ridout Road Annapolis, Maryland 21401   |  |  |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Boiling Springs Presbyterian  |                                | Date<br>May 10 1996   |  | 20c. Location - City or Town, State<br>Spring Church, PA   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                                | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke Of Gloucester St. Annapolis, MD 21401   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Acute Cerebrovascular Accident</u><br>Due to (or as a consequence of):<br>b. <u>Old Cerebrovascular Accident</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| State Registrar   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |   |  |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                | 28d. Describe how Injury occurred   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
|   | 29b. Signature and title of certifier<br>Attending Doctor   |  |   |                                | 29c. License number<br>D21684   |  | 29d. Date signed (Month, Day, Year)<br>May 8, 1996   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>C.V. Cyriac, M.D. 1600 Crain Highway Glen Burnie, MD 21061 (410-768-4242) |   |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 09 1996  |   | 32. Registrar's Signature<br>  |   |                                |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 14949

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Jean Dorset Faulkner Bradbury</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>April 30 1996</u>  |  | 3. TIME OF DEATH<br><u>8:45A</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>494-12-6452</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>80</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>Oct 14 1915</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Virginia</u>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>1353 Moyer Road</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Annapolis</u>   |  | 9c. COUNTY OF DEATH<br><u>Anne Arundel</u>  |  |
| 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY<br><u>Anne Arundel</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Annapolis</u>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>9 Melrob Court</u>  |  | 10f. ZIP CODE<br><u>21403</u>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Administrator</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Providence Center</u>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Sterling B. Faulkner</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Kate S. Dorset</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Barbara B. Brashears</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1353 Moyer Road Annapolis, Maryland 21403</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>May 3, 1996</u><br><u>Hillcrest Memorial Gardens</u>   |  | 20c. LOCATION — City or Town, State<br><u>Annapolis, Maryland</u>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Donald A. Lytle</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>John M. Taylor Funeral Home</u><br><u>147 Duke Of Gloucester St. Annapolis, MD</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ACQUANOUS CELL CANCER BRADYCARDIA</u> 1989<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <u>96</u><br>c. <u>7yr</u><br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>NO RELATIONSHIP TO SMOKING</u><br><u>KNOWN</u>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>John M. Taylor</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>DO 8118</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>4/30/96</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>STANLEY WATKINS JR 900 BESTGATE RD ANN MD 21401</u>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAY 02 1996</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14950

## Certificate of Death

Reg. No.

|                                     |   |  |   |  |   |  |
|-------------------------------------|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedant's Name (First, Middle, Last)<br><b>THALSBURG BROWN</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 28 1996</b>  |  | 3. Time of Death<br><b>1-00 PM</b>  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>219-64-3632</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.  |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 29 1955</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>D.C.</b>   |  |   |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>HANOVER</b>   |  |
|                                     | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |
|                                     | 10e. Street and Number<br><b>7737 HARMANS ROAD</b>  |  | 10f. Zip Code<br><b>21076</b>   |  | 10g. Citizen of What Country?<br><b>US</b>  |  |
|                                     | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedant Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |  |   |  |
|                                     | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>ARCHIE C. BROWN &amp; SONS TRASH REMOVAL</b>   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>ARCHIE C. BROWN JR.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN TAYLOR</b>  |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>HELEN WILLIAMS (MOTHER)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7737 HARMANS ROAD HANOVER, MD. 21076</b>  |  |   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANNAPOLIS MEM. GARDENS</b>   |  | 20c. Location - City or Town, State<br><b>ANNAPOLIS, MD.</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Harry B. Reese</b>  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>3 DAYS</b>   |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CARDIOMYOPATHY</b><br><b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b>  |  |   |  |   |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>1</b> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |  |
|                                     | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Julia Davidson-Randall, MD</b>  |  | 29c. License number<br><b>D 46962</b>   |  |
|                                     | 29d. Date signed (Month, Day, Year)<br><b>APRIL 28 1996</b>   |  |   |  |   |  |
| State<br>Registrar                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. SHIRAZI, MD - HOUSE PHYSICIAN - NORTH ARUNDEL HOSPITAL. MD 21061.</b>   |  |   |  |   |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14951

|  |  |  |  |   |  |  |   |   |
|--|--|--|--|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Richard John Bell                  |  |  |   | 2. Date of Death<br>Month Day Year<br>May 2, 1996                                    |  | 3. Time of Death<br>7: 20 a. m.                     |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>P.O. Box 788 |  |  |   | 4b. City, Town, or Location of Death<br>Huntingtown                                  |  | 4c. County of Death<br>Calvert                      |   |
| Funeral<br>Director  | 5. Social Security Number<br>577-58-3866                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>52 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec 20, 1943 | 9. Birthplace (State or Foreign Country)<br>Bridgeport, CT  |
|  | Usual Residence of Decedent  |  |  |   | 10f. Zip Code<br>20639   |  | 10g. Citizen of What Country?<br>United States      |   |
| 10a. State<br>Maryland   |  | 10b. County<br>Calvert   |  | 10c. City, Town or Location<br>Huntingtown  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 10e. Street and Number<br>P.O. Box 788   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:             |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retired Inspector  |  | 16b. Kind of Business/Industry<br>P.G. County Government   |   |   |
| 17. Father's Name (First, Middle, Last)<br>Robert Croft Bell   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Gertrude Sullivan   |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Thomas Bell  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4233 Drake Court, Waldorf, Maryland 20639  |  |  |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resurrection Cemetery   |  | 20c. Location - City or Town, State<br>Clinton, Maryland   |   |   |
| 21. Signature of Funeral Service Licensee<br>Stanley E. Marselas   |  |  |  | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735   |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Renal Cell Carcinoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br>7 year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |
|  |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                   |   |
|  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |   |
| 29b. Signature and title of certifier<br>Michael P. Dipre, M.D.  |  |  |  | 29c. License number<br>038991   |  | 29d. Date signed (Month, Day, Year)<br>May 3, 1996   |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Michael P. Dipre, M.D. P.O. Box 1428 Solomons MD 20688   |  |  |  |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 08 1996   |  |  |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14952

Amended #20a, 5/8/96, Talbot Certificate of Death LMG

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William George Bodenstein</b>  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>4:35 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6173 Bellevue Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Royal Oak</b>   |  | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>054-12-2508</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 24, 1913</b>                       |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Talbot</b>   |  | 10c. City, Town or Location<br><b>Royal Oak</b>                                  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6173 Bellevue Road</b>   |  | 10f. Zip Code<br><b>21662</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Entomologist</b>  |  | 16b. Kind of Business/Industry<br><b>Agriculture</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Otto Bodenstein</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma V. Chapman</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Otelia Bodenstein Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6173 Bellevue Road, Royal Oak, MD. 21662</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory</b>  |  | 20c. Location - City or Town, State<br><b>May 7, 1996 Dover, Delaware</b>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>   |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 South Talbot St., St. Michaels, MD 21663</b>  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC PROSTATE CA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>035259</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/7/96</b>   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kevin J. O'Keefe, M.D. 606 Dutchmans Lane, Easton, Maryland 21601</b>  |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 08 1996</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table, but the characters are too light to transcribe accurately.]*

96 14953

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN FRANKLIN BAKER, JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 1 1996</b>   |  | 3. TIME OF DEATH<br><b>11:00 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-36-0535</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAR. 27, 1924</b>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>29410 MAPLE AVENUE</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TRAPPE</b>  |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>TALBOT</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TRAPPE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>29410 MAPLE AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21673</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARMER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FARMING</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>J. FRANKLIN BAKER, SR.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET MITCHELL</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LOIS V. BAKER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 111, TRAPPE, MD 21673</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY 5-4</b>   |  | 20c. LOCATION — City or Town, State<br><b>EASTON, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>JOHN R. MERCERON CFS</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL<br/>200 S. HARRISON ST., EASTON, MD</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Arteriosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>10 yrs</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Heart Disease with Myocardial Infarction<br/>Inflammatory Bowel Disease</b>   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><b>William H. Wood Jr. MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D08715</b>  |  | 29d. DATE SIGNED (Month/Day/Year)<br><b>5/03/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 07 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Woodard</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





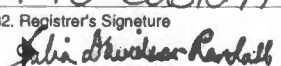
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14954

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>George O. Cross</b>                              |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1996</b>                          |  | 3. Time of Death<br><b>12:08 pm</b>                        |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Bayview Medical Center</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>                                  |  | 4c. County of Death<br><b>n/a</b>                          |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-18-9924</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1923</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |   | 10. Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>n/a</b> 10c. City, Town or Location <b>Baltimore</b> |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>1008 Armstead Way</b>   |   | 10f. Zip Code<br><b>21205</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>disabled</b>  |   | 16b. Kind of Business/Industry<br><b>n/a</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Lee Cross</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Mae Ridgley</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Linda M. Schofield/daughter</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9719 Conmar Road, Baltimore, Maryland 21220</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>   |  | 20d. Date<br><b>4-29-96</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00535</b>   |   | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>Ellicott City, Maryland 21043</b>   |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Cardiac arrest</b><br>Due to (or as a consequence of): <b>ASCVD</b><br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>&lt;1 hr.</b>   |   |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>C. Marco MD</b>  |   |   |   | 29c. License number<br><b>D37586</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/27/96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C. MARCO, MD, 4940 Eastern Ave, Baltimore, MD 21224</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |   |   |   | 32. Registrar's Signature<br>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

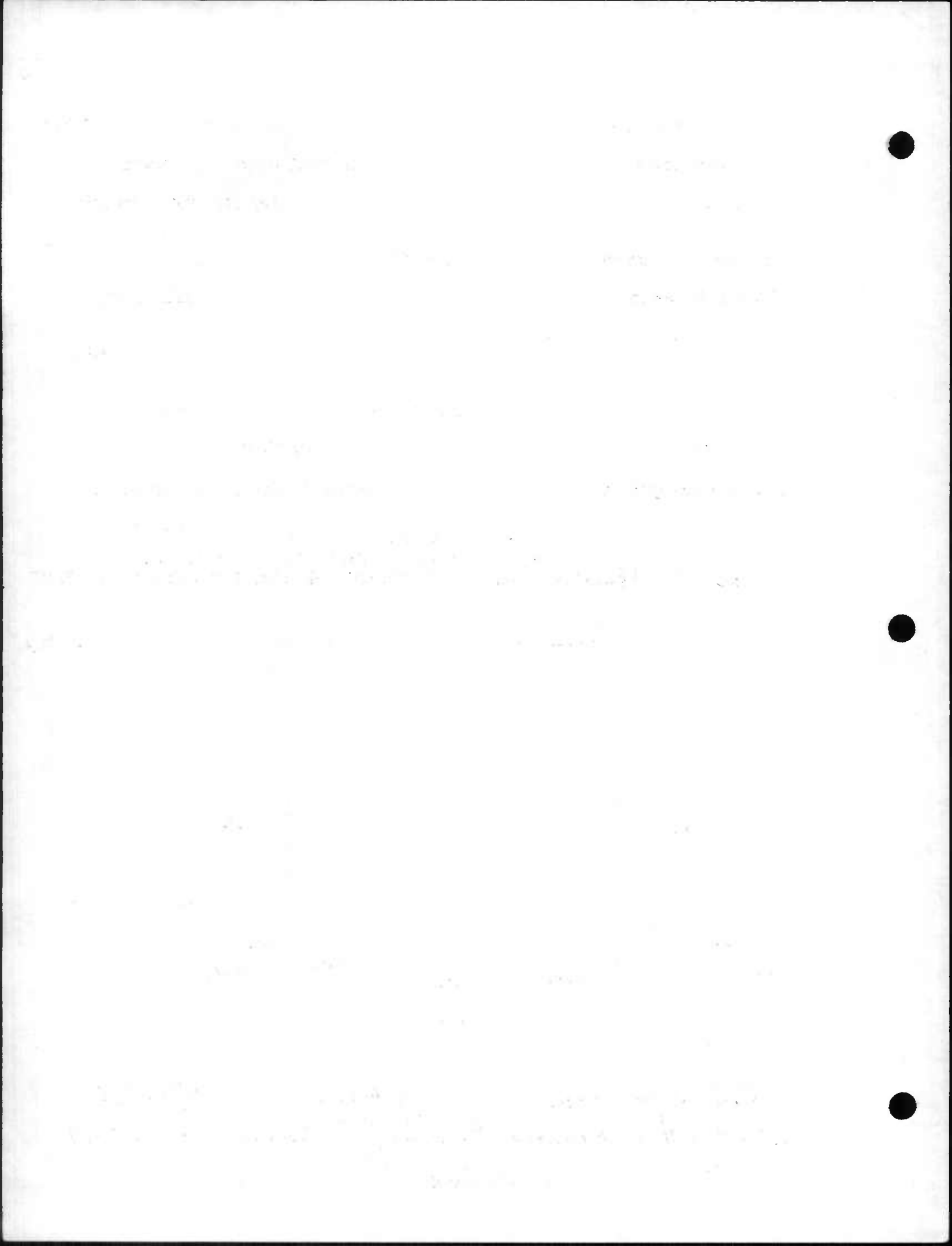
96 14955

Reg. No.

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Cruey</b>                              |   |  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 24 1996</b>              |  | 3. Time of Death<br><b>6:00pm</b>                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>8321 Court Avenue</b> |   |  |   |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>            |  | 4c. County of Death<br><b>Howard</b>                        |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>411-54-6726</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 14, 1936</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |   |  |   |  |
| 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Ellicott City</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>8321 Court Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21043</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Gounds Keeper</b>   |  |  | 16b. Kind of Business/Industry<br><b>Country Club</b>                   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosa Cruey</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Cruey/Wife</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8321 Court Avenue Ellicott City, MD 21043</b>  |   |  |   |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>  |  | Date<br><b>4-29-96</b>   |   | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>                                   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Sharon A. Collins-Witzke</b>   |  |   |  |   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>                   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Non-Small Cell Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |  |   |  |   |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>N/A</b>   |  |   |  |   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28e. Date of Injury (Month, Day Year)<br><b>N/A</b>   |  | 28b. Time of injury<br><b>N/A</b> M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |  |   |  |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Knight</b>   |  |   |  |   |  | 29c. License number<br><b>241139</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/26/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Knight<br/>11065 Little Retreat Parkway, Columbia MD 21044</b>  |  |   |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1996</b>  |  |   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14956

|   |  |   |  |  |   |  |  |   |
|---|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roy William Chrest</b>                          |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>30</b> Year <b>1996</b> |  | 3. Time of Death<br><b>3:54 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>               |  | 4c. County of Death<br><b>Howard</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-12-6421</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 19, 1920</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Glenelg</b>  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>14205 Pioneer Circle</b>   |  |   |  | 10f. Zip Code<br><b>21737</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chemist</b>  |   | 16b. Kind of Business/Industry<br><b>Pigment Division/SCM</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Roy Lester Chrest</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elise Marie Chrest</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Mary L. Chrest/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14205 Pioneer Circle Glenelg, Maryland 21737</b>   |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crest Lawn Cemetery</b>  |  | Date<br><b>5-3-96</b>  |   | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Shawn A. Collins - Witzke</b>   |  |   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. <b>Hypercholesterolemia</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Mei-Hui Wang</b>  |  | 29c. License number<br><b>D45972</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 1996</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr Wong<br/>11055 Little Patuxent Parkway Columbia, MD 21044</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson Randall</b>  |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14957

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br>Ruth L. Charity  |  |  |  | 2. Date of Death<br>Month Day Year<br>April 26, 1996   |  | 3. Time of Death<br>4:00 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Greenbelt Nursing Home   |  |  |  | 4b. City, Town, or Location of Death<br>Greenbelt  |  | 4c. County of Death<br>Prince George's  |  |
| Funeral<br>Director  | 5. Social Security Number<br>579 42 6694   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>72 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 18, 1924   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  | 10a. State<br>DC   |  | 10b. County<br>None  |  | 10c. City, Town or Location<br>Washington   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br>2824 12th Street NE # 101  |  | 10f. Zip Code<br>20017  |  |
|  | 10g. Citizen of What Country?<br>USA   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedant Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |   |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |  |  |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lawyer  |  |   |  |
|  | 16b. Kind of Business/Industry<br>Self Employed  |  |  |  | 17. Father's Name (First, Middle, Last)<br>C. L. Harvey  |  |   |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Lovelace  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Khris Charity stepson  |  |   |  |
|  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>771 Pine Drift Way Odenton, MD 21113  |  |  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |
|  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oakhill Cemetery   |  |  |  | 20c. Location - City or Town, State<br>5/2 Danville, Virginia  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>► Nelson E. Greenleaf   |  |  |  | 22. Name and Address of Facility<br>GREENE FUNERAL HOME<br>814 Franklin Street<br>Alexandria, VA 22314   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. ANOXIC ENCEPHALOPATHY<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. {<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |   |  |
| Approximate Interval Between Onset and Death<br>2 MONTHS   |  |  |  |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension   |  |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |
|  | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 28d. Describe how Injury occurred  |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br>► George C. Hajjar, Jr. M.D.  |  |  |  | 29c. License number<br>039550  |  | 29d. Date signed (Month, Day, Year)<br>4-26-96  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  |  |  | 32. Registrar's Signature<br>John Anderson |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ANTHONY J. MARSHALL  
JAN 11 1964  
ALBANY, N.Y.

2100-1-10-10 1001 8 8 8 4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14958

Amended # 1, P.G.C. 4-30-96 cr

## Certificate of Death

Reg. No.

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><del>EULA</del> <b>U.L.A. MARJORIE CHARLES</b> |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 18, 1996</b>  |                                | 3. Time of Death<br><b>9:00 PM</b>   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>6609 100th ave</b>    |   |  | 4b. City, Town, or Location of Death<br><b>SEABROOK</b>  |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>077-40-5922</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 29, 33</b> |
|  | 9. Birthplace (State or Foreign Country)<br><b>TRINIDAD, W.I.</b>                          |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>SEABROOK</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>6609 - 100th AVENUE</b>   |  |   |  | 10f. Zip Code<br><b>20706</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE AIDE</b>   |                                | 16b. Kind of Business/Industry<br><b>PRIVATE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>ALBERT WYKE</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>INEZ COX</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>APRIL WYKE-RANSOME (DAUGHTER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6609 - 100 AVENUE : SEABROOK, MD. 20706</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK</b>  |  | Date<br><b>4/27/96</b>   |                                | 20c. Location - City or Town, State<br><b>LANDOVER, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>JOHNSON &amp; JENKINS FUNERAL HOME, INC.<br/>716 KENNEDY STREET, N.W.: WDC 20011</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |                                |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Blunt Force Injuries to Head</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |  |  |                                |  |  |
| Approximate interval Between Onset and Death   |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Found 4/18/96</b>  |  | 28b. Time of Injury<br><b>1630 HRS</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred<br><b>Subject beaten</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>6609 100th Avenue Seabrook Prince Georges County Maryland</b>   |                                |  |  |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>APRIL 19, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1996</b>  |  | 32. Registrar's Signature<br>  |  |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14959

Amended # 19 a. PGC 5-7-96 cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHING HUA CLEGG

2. Date of Death

Month Day Year  
APRIL 28, 1996

3. Time of Death

3:05 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MAGNOLIA GARDENS NURSING HOME

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

5. Social Security Number

223-96-1483

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 13 1951

9. Birthplace (State or Foreign Country)

Taiwan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel, Maryland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15609 Dorset Road #102

10f. Zip Code

20707

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Chinese American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Production Inspector

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Chung Hung Lue

18. Mother's Name (First, Middle, Maiden Surname)

Mou Jeg Cheng

19a. Informant's Name/Relationship (Type, Print)

Charles  
Charles R. Brooks, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15609 Dorset Road #102 Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

5/2

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Alex S. Pope

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE, FORESTVILLE, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRAIN metastasis (Carcinoma)

Due to (or as a consequence of):

b. Undifferentiated Carcinoma - origin unclear

Due to (or as a consequence of):

c. Liver, lung, bone metastasis; Squamous cell carcinoma

Due to (or as a consequence of):

d. Lt Hemiplegia and Right facial sensory deficit Central Metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Sarastoatty Ranachandran M.D.

29c. License number

D40395

29d. Date signed (Month, Day, Year)

4/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sarastoatty Ranachandran, MD 7500 GREENWAY CENTER DRIVE, GREENBELT, MD. 20770

31. Date filed (Month, Day, Year)

MAY 02 1996

32. Registrar's Signature

John H. ...

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12 1/11

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document discusses the role of the accounting department in the overall management of the organization. It highlights the department's responsibility for providing accurate and timely financial information to management and other stakeholders.

4. The fourth part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for ensuring the integrity of the financial system and for providing a clear audit trail.

5. The fifth part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

6. The sixth part of the document discusses the role of the accounting department in the overall management of the organization. It highlights the department's responsibility for providing accurate and timely financial information to management and other stakeholders.

7. The seventh part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for ensuring the integrity of the financial system and for providing a clear audit trail.

8. The eighth part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14960

## Certificate of Death

Reg. No.

|  |   |                                       |   |   |  |  |   |  |
|--|---|---------------------------------------|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Anna M. Clancy</b>   |                                       |   |   | 2. Date of Death<br>Month Day Year<br><b>April 27 1996</b>   |  | 3. Time of Death<br><b>9:44 PM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Larkin-Chase Nursing Center</b>  |                                       |   |   | 4b. City, Town, or Location of Death<br><b>Bowie</b>   |  | 4c. County of Death<br><b>Prince George's</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>114 24 3846</b>   | 6. Sex<br><b>1 M 2 F</b>              | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 15, 1903</b>                                   |   | 9. Birthplace (State or Foreign Country)<br><b>Ireland</b> |
|  | Usual Residence of Decedent   |                                       |   |   |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b> | 10c. City, Town or Location<br><b>College Park</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>7329 Baylor Ave.</b>   |                                       |   | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|  | 11. Marital Status<br><b>1 Navar Married 2 Married 3 Widowed 4 Divorced</b>   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b> If Yes, Give Year or Dates:      |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:           |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8 College (1-4or 5+)</b>  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietician</b>                       |  | 16b. Kind of Business/Industry<br><b>Life Insurance</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles McDermott Roe</b>   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Beirne</b>   |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles P. Clancy Son</b>  |                                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8437 Greenbelt Rd. Greenbelt Maryland 20770</b> |  |  |   |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calvary Cemetery</b> |   | Date<br><b>May 1, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Woodside New York</b>         |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert E. Evans Pres</b>  |                                       |   | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>                          |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Diabetes</b><br>Due to (or as a consequence of):<br><b>c. Heart failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                       |   |   |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |                                       |   |   |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |                                       |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |   |  |
|  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |                                       |   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |
|  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |                                       | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>                               |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                       | 28d. Describe how injury occurred   |   |  |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                       |   |   |  |  |   |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>  |                                       |   |   | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>054705</b>                                    |  |
|  | 29d. Date signed (Month, Day, Year)<br><b>4/29/96</b>   |                                       |   |   |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Dobin 5231 Spruce Lane A.C. Bowie MD 20715</b>  |                                       |   |   |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |                                       |   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 800-858-8000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2000 10 20 09:00

96 14961

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ellsworth Carter</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28 1996</b>  |  | 3. TIME OF DEATH<br><b>3:35 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-48-7670</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 2, 1926</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, DC</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel, MD</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Howard</b>  |  |   |  | 10a. STATE<br><b>DC</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1114 Allison Street N.W.</b>   |  |
| 10f. ZIP CODE<br><b>20011</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Brick Layer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Robert Fernold Construction Co.</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Carter</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorothy Brown</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy B. Chapman</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1114 Allison Street N.W., Wash., DC 20011</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |  | 20c. DATE<br><b>5-4</b>   |  | 20d. LOCATION — City or Town, State<br><b>Landover, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. P. Marshall</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th St. N.W., Wash., DC 20011</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypertension</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>10 years</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Margolis MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D25430</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 28, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Margolis, MD 14333 Laurel-Bowie Rd #307 Laurel, MD 20708</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 02 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Marshall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14962

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIE CANTY</b>   |   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>24</b> Year <b>1996</b> |   | 3. Time of Death<br><b>5:45PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hosp. 3001 Hospt. Dr.</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>               |   | 4c. County of Death<br><b>Prince Georges</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-40-7914</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 4, 1919</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>So. Carolina</b>   |   | 10a. State<br><b>DC</b>  |  | 10b. County<br><b>None</b>  |   | 10c. City, Town or Location<br><b>Washington, D. C.</b>    |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>278 15th Street, S. E.</b>   |  | 10f. Zip Code<br><b>20003</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                    |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouseman</b>  |  | 16b. Kind of Business/Industry<br><b>Grocery Store</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>James Canty</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Martin</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lizzie Canty (Wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>278 15th Street, SE; Wash., DC. 20003</b>  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery</b>  |   | 20c. Date<br><b>Apr. 29, 1996</b>   |  | 20d. Location - City or Town, State<br><b>Landover, MD.</b>  |   | 21. Signature of Funeral Service Licensee<br><b>Ralph Williams</b>  |  |  |
| 22. Name and Address of Facility<br><b>Ralph Williams Funeral Service</b>  |   | 22. Name and Address of Facility<br><b>517 - 11th Street, SE; Wash., DC</b>   |  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Aspiration Pneumonia</b> |   | Approximate Interval Between Onset and Death<br><b>7 Days</b>   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>M. Karim MD</b>   |  | 29c. License number<br><b>D-18895</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |  | 32. Registrar's Signature<br><b>John H. ...</b>  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14963

## Certificate of Death

Reg. No.

Amended # 17. P.G.C. 5-7-96 cr

|   |  |  |   |                                      |   |  |   |  |  |  |
|---|--|--|---|--------------------------------------|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Susie F. Clinton</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>April 29, 1996</b>   |  |   |  | 3. Time of Death<br><b>11:00 pm</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Magnolia Gardens Nursing Home</b>   |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-05-4583</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 11, 1910</b>                |  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>  |  |
|   | Usual Residence of Decedent  |  |   |                                      |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |                                      | 10c. City, Town or Location<br><b>Berwyn Heights</b>  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>8802 60th Avenue</b>  |  |   |                                      | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                              |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)   |  |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  |   | 16b. Kind of Business/Industry<br><b>D.C. Post Office</b>                    |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Robert C. <del>Franklin</del> Faulkner</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Whitesides</b>  |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn C. Bernhard</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8802 60th Avenue, Berwyn Heights, Maryland 20740</b>  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>05/02/96 Alexandria, Virginia</b> |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>W.B. Gasch</b>   |  |   |                                      | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. pneumonia</b><br>Due to (or as a consequence of):<br><b>b. complete stroke</b><br>Due to (or as a consequence of):<br><b>c. Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                      |   |  |   |  |  |  |
|   | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>years</b><br><b>years</b>  |  |   |                                      |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                      |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |   |                                      |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |  |   |                                      |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                                      | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |                                      | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  |  |   | 28d. Describe how injury occurred    |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                                      |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. T. Chanchien, M.D.</b>  |  |  |   | 29c. License number<br><b>D13339</b> |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 1996</b>                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. T. Chanchien, M.D. 8824 Cunningham Drive, Berwyn Heights, Maryland 20740</b>   |  |  |   |                                      |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |  |  |   |                                      |   |  |   |  |  |  |
| 32. Registrar's Signature<br><b>J. H. [Signature]</b>   |  |  |   |                                      |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



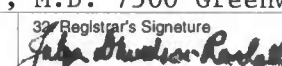
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14964

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |                          |   |   |  |  |
|---|---|--|---|---|---|--------------------------|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GOLDIE INGEBOG CHANEY   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 30, 1996  |                          |   |   | 3. Time of Death<br>6:30 pm                                      |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Sacred Heart Home   |  |   |   | 4b. City, Town, or Location of Death<br>Hyattsville   |                          |   |   | 4c. County of Death<br>Prince George's                           |  |
| Funeral<br>Director   | 5. Social Security Number<br>526-22-4364  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                    |   | 7. Age (In yrs. last birthday)<br>90 Yrs.   |                          | 8. Date of Birth (Month, Day, Year)<br>June 2, 1905   |   | 9. Birthplace (State or Foreign Country)<br>Sweden               |  |
|   | Usual Residence of Decedent   |  |   |   | 10e. State<br>MD  |                          | 10b. County<br>Prince George's  |   | 10c. City, Town or Location<br>Hyattsville                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   | 10f. Zip Code<br>20782  |                          |   |   | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |                          |   |   | 16b. Kind of Business/Industry<br>Private Industry               |  |
|   | 17. Father's Name (First, Middle, Last)<br>Andrew Johnson   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hulda Johnson  |                          |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Margery Chaney - Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7215 Windsor Lane, Hyattsville, Maryland 20782   |                          |   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery |   | Date<br>05/04/96  |                          | 20c. Location - City or Town, State<br>Silver Spring, MD  |   |  |  |
|   | 21. Signature of Funeral Service licensee<br>   |  |   |   | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781   |                          |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. pneumonia<br>Due to (or as a consequence of):<br>b. aspiration<br>Due to (or as a consequence of):<br>c. esophageal stricture<br>Due to (or as a consequence of):<br>d. gastro-esophageal reflux disease |  |   |   | Approximate interval Between Onset and Death<br>24 hours<br>24 hours<br>decades<br>decades  |                          |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Senile dementia   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                          |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                          |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br>  |   |                          |   | 29c. License number<br>022780   |  |  |
| 29d. Date signed (Month, Day, Year)<br>5/3/96   |   |  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770 |   |                          |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 03 1996  |   |  |   | 32. Registrar's Signature<br>  |   |                          |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14965

## Certificate of Death

Reg. No.

|                                     |   |  |  |   |  |   |  |   |  |  |
|-------------------------------------|---|--|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>STEVEN A. COOKE</b>  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>30</b> Year <b>1996</b> |  |   | 3. Time of Death<br><b>6:12 Am</b>   |   |  |  |
|                                     | 4e. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>               |  |   | 4c. County of Death<br><b>PRINCE GEORGE'S</b>                                    |   |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>579-64-3766</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>08-21-49</b>                           |   | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>                               |  |
|                                     | Usual Residence of Decedent   |  |  |   |  |   |  |   |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Hyattsville</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                     | 10e. Street and Number<br><b>7505 Garrison Road</b>   |  |  |   | 10f. Zip Code<br><b>20784</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |   |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1969/1970</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+) <b>2+</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Program Analyst</b>  |   |  | 16b. Kind of Business/Industry<br><b>Government</b>                     |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Chester A. Cooke</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Scott</b>   |   |  |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Cooke/Wife</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7505 Garrison Rd, Hyattsville, MD 20784</b>  |   |  |   |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |   | Date<br><b>5/4/96</b>  |   | 20c. Location - City or Town, State<br><b>Landover, MD</b>                       |   |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Nancy A. Percantie</b>  |  |  |   | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Rd, Landover, MD 20785</b>   |   |  |   |  |  |
|                                     | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Cardio-Vascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |  |  |   |  |   |  |   |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Obesity</b>  |  |  |   |  |   |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |   |  |   |  |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |  |   |  |  |
|                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |   |  |   |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|                                     | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |
|                                     | 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |  |   |  |   |  |  |
|                                     | 29b. Signature and title of certifier<br><b>Nancy A. Percantie MD</b>   |  |  |   | 29c. License number<br><b>D25925</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>April 30, 1996</b>            |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. BERGER MD #205, 7720 WILSONSIN AVE, Bethesda MD 20814</b>   |  |  |   |  |   |  |   |  |  |
|                                     | State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 03, 1996</b> |  | 32. Registrar's Signature<br><b>Juan [Signature]</b>                  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

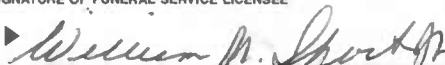

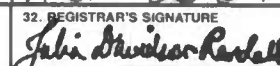




96 14966

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lawrence F. Coville</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 29, 1996</b>   |  | 3. TIME OF DEATH<br><b>9:30 P. M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>051-01-3896</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 2, 1904</b>                           |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5225 Cooper Road</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Eden</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Wicomico</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Delmar</b>   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>33361 Melson Road</b>  |  |  |   |
| 10f. ZIP CODE<br><b>21875</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales Representative</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Precious Metals</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Coville</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Cook Coville</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>June E. Simpson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>33361 Melson Road Delmar, MD. 21875</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cambridge Crematory</b>  |  | DATE<br><b>5-2</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, Md.</b>                         |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Short Funeral Home, Inc.<br/>13 E. Grove ST. Delmar, DE. 19940</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. IRON DEFIC. ANEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. WEIGHT LOSS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. GI BLEED</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 mo.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SUSPECTED GI MALIGNANCY</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  |   |  |  |   |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D29168</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/30/96</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Robert Allen 560 Riverside Dr., Suite A204, Salisbury, MD 21801</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 01 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14967

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) John Arthur Cirioni  
 2. Date of Death Month Day Year 4 29 96  
 3. Time of Death 1330

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center  
 4b. City, Town, or Location of Death Salisbury  
 4c. County of Death Wicomico  
 5. Social Security Number 003-32-6784  
 6. Sex ☒ M ☐ F  
 7. Age (In yrs. last birthday) 49 Yrs.  
 8. Date of Birth (Month, Day, Year) 9-20-46  
 9. Birthplace (State or Foreign Country) Massachusetts

Usual Residence of Decedent

10a. State Maryland  
 10b. County Wicomico  
 10c. City, Town or Location Salisbury  
 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 152 Onley Road  
 10f. Zip Code 21804  
 10g. Citizen of What Country? USA

11. Marital Status  
 1 ☐ Never Married 2 ☒ Married  
 3 ☐ Widowed 4 ☐ Divorced  
 12. Was Decedent Ever in U.S. Armed Forces?  
 1 ☒ Yes 2 ☐ No  
 If Yes, Give Year or Dates: Viet Nam  
 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 1 ☐ Yes 2 ☒ No Specify:  
 14. Race - American Indian, Black, White, etc.  
 Specify: white

15. Decedent's Education (Specify only highest grade completed)  
 Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  
 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Central Office Technician  
 16b. Kind of Business/Industry Bell Atlantic

17. Father's Name (First, Middle, Last) Arthur Cirioni Sr.  
 18. Mother's Name (First, Middle, Maiden Surname) Frances Hunter

19a. Informant's Name/Relationship (Type, Print) Martina R. Cirioni/spouse  
 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 Onley Rd., Salisbury, MD 21804

20a. Method of Disposition  
 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
 4 ☐ Donation 5 ☐ Other (Specify)  
 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory  
 Date 5/1/96  
 20c. Location - City or Town, State Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home  
 501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. multiple trauma

26 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
 2 ☒ Accident 6 ☐ Could not be determined  
 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 4/28/96

28b. Time of Injury 1100 M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Driver motor cycle striking auto

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Delaware Route 24 at Route 437

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Laurel, Delaware

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D.M.E.

29c. License number

D03599

29d. Date signed (Month, Day, Year)

4/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John T. Bulkeley, M.D. 108 Pine Bluff Road, Salisbury, MD

31. Date filed (Month, Day, Year)

MAY 02 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1954

1954

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14968

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |   |  |  |  |
|---|--|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Carroll D Cantler  |   |   |  | 2. Date of Death<br>Month Day Year<br>May 3 1996   |  |   |  | 3. Time of Death<br>2:55 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>199 Melody Lane  |   |   |  | 4b. City, Town, or Location of Death<br>Arnold   |  |   |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-40-9612   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F<br>X   |  | 7. Age (In yrs. last birthday)<br>56 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Apr. 23 1940       |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Arnold  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No X |  |
|   | 10e. Street and Number<br>199 Melody Lane  |   |   |  | 10f. Zip Code<br>21012   |  | 10g. Citizen of What Country?<br>United States            |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 Collegia (1-4 or 5+) 8  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waterman  |  |   | 16b. Kind of Business/Industry<br>Seafood                        |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Louis D. Cantler  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth L. Ritchie  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Debra L. Cantler /Wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>199 Melody Lane Arnold, Maryland 21012  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory  |  | Date<br>May 7 1996   |  | 20c. Location - City or Town, State<br>Brentwood Maryland |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>John M. Taylor</i>   |   |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |  |  |
|   | Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Adenocarcinoma Squamous Cell Carcinoma of lung</i> 9 months<br>Due to (or as a consequence of):<br>b. <i>Carcinoma invasion of the Esophagus</i> 6 months<br>Due to (or as a consequence of):<br>c. <i>Malnutrition</i> 3 months<br>Due to (or as a consequence of):<br>d. |   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |  |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Smoking</i><br><i>Excess Alcohol ingestion chronically</i>  |   |   |  |  |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |  |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |   |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |  |  |  |
| State Registrar   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |   |  |  |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined  |   |   |  |  |  |   |  |  |  |
|   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |   |  |  |  |
| State Registrar   | 28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><i>John P. Serlemitsos</i>  |   |   |  |  |  |   |  |  |  |
|   | 29c. License number<br>032654  |   |   |  |  |  |   |  |  |  |
| State Registrar   | 29d. Date signed (Month, Day, Year)<br>May 3, 1996   |   |   |  |  |  |   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>John P. Serlemitsos, 180 Admiral Cochrane Drive, Annapolis, Md. 21401  |   |   |  |  |  |   |  |  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br>MAY 07 1996   |   |   |  |  |  |   |  |  |  |
|   | 32. Registrar's Signature<br><i>Julia Davidson-Rendell</i>   |   |   |  |  |  |   |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GLENN S. CAVINEE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>1</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>-130-PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>290-01-0795</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-22-1914</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Ctr.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>84 N. Old Mill Bottom Rd.</b>   |  |
| 10f. ZIP CODE<br><b>21401</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Insurance Adjuster</b>  |  |  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>   |  |  |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>Beryl Cavinee</b>   |  |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Siebern</b>   |  |  |  |
| 20. INFORMANT'S NAME (Type/Print)<br><b>H. Chester Goudy, Jr.</b>   |  |  |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>617 Cape McKinsey Drive Severna Park MD 21146</b>  |  |  |  |
| 22. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Washington Cemetery 5/4 Washington CH, Ohio</b>  |  |  |  |
| 24. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 25. NAME AND ADDRESS OF FACILITY<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy Severna Park MD 21146</b>   |  |  |  |
| 26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>EMPHYSEMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>BRONCHOPNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>ACUTE RENAL FAILURE</b> |  |  |  |   |  |  |  |
| 27. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE RENAL FAILURE</b>  |  |  |  |   |  |  |  |
| 28. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 30. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 31. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 32. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 33. DATE OF INJURY (Month, Day, Year)<br><b>5/4</b>   |  |  |  |
| 34. TIME OF INJURY<br><b>M</b>  |  |  |  | 35. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  |  |  | 37. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 38. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>At home</b>   |  |  |  | 39. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 40. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 41. LICENSE NUMBER<br><b>023142</b>   |  |  |  |
| 42. DATE SIGNED (Month, Day, Year)<br><b>5/1/96</b>   |  |  |  | 43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S.D. KRIMINS, M.D. 900 ABBEY RD. ST 300 ANNAPOLIS, MD 21403</b>   |  |  |  |
| 44. DATE FILED (Month, Day, Year)<br><b>MAY 03 1996</b>   |  |  |  | 45. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1845-1846



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14970

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |   |  |  |
|---|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BIRDIE CAYEY</b>                                 |   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>29TH</b> Year <b>1996</b> |   | 3. Time of Death<br><b>3:30 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie, MD</b>          |   | 4c. County of Death<br><b>AA Anne Arundel</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-28-9752</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                        |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 11, 1914</b>  |  |
|   | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>                                      |   | 10c. City, Town or Location<br><b>Crownsville</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>Fairfield Loop Rd.</b>   |  | 10f. Zip Code<br><b>21032</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b>College</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk Stock Room</b>  |  | 16b. Kind of Business/Industry<br><b>Glass Pittsburgh Plate</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles M. Weidner</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Myers</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Caye Day</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>688 209th Street Pasadena, Maryland 21122</b>  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>MD Baltimore,</b>  |   | 20d. Date<br><b>5-2-1996</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>James E. Parsons</i>  |   |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy. Severna Park, MD 21146</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>STROKE</b>  |   |   |  |  |   |   | Approximate Interval Between Onset and Death<br><b>36 Hours</b>  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b>   |   |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Suparna</i>   |   | 29c. License number<br><b>D48006</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 29TH, 1996</b>   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KOFI J. WASH - BOWTEY, 301 HOTT DR, GLEN BURNIE, MD 21061</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1996</b>   |   | 32. Registrar's Signature<br><i>Fisher Davidson-Rendell</i>   |  |  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



96 14971

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOLORES G. COLLINS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>7</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>10:30 AM</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-32-0820</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 28, 1936</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>301 RAILROAD AVENUE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ST. MICHAELS</b>   |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>TALBOT</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>ST. MICHAELS</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>301 RAILROAD AVENUE</b>   |  |  |  | 10f. ZIP CODE<br><b>21663</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) _____   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CARE-GIVER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME HEALTH CARE</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RAYMOND C. REAM</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>WINONA ADA ROSENBERGER</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>THOMAS R. COLLINS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301 RAILROAD AVE., ST. MICHAELS, MD 21663</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY</b>   |  | DATE<br><b>5-10</b>  |  | 20c. LOCATION — City or Town, State<br><b>EASTON, MD</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>JOHN R. MERCERON LFS</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL H.<br/>200 S. HARRISON ST., EASTON, MD 21601</b>   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC LUNG CARCINOMA</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. _____ |  |  |  |  |  |   | Approximate interval Between Onset and Death<br><b>6mo</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEIZURE DISORDER</b>  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. Bremer</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26350</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5/8/96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM S. BREMER, M.D., 800 S. TALBOT ST., ST. MICHAELS, MD 21663</b>   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 09 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14972

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Louise Cottone</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>05</b> DAY <b>04</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>3:00 p.m.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>444-09-4293</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 19, 1912</b>                                     |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WM. HILL HEALTH CARE CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>EASTON</b>  |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>TALBOT</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>EASTON</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>501 DUTCHMAN'S LANE</b>   |  |  |  | 10f. ZIP CODE<br><b>21601</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>NORMAN FREDERICK CLEVERDON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY INA MCCRAY</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MICHAEL B. COTTONE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9455 ELLSWORTH COURT, FULTON, MD. 20759</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>CHESAPEAKE CREMATION</b>  |  | OATE<br><b>5-6</b>  |  | 20c. LOCATION — City or Town, State<br><b>CHESTER, MD.</b>                                      |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>M. E. Decker III CFSR</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM</b><br><b>811 S. HARRISON ST., EASTON, MD. 21601</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiovascular accident</b><br>Due to (or as a consequence of):<br>a. <b>atherosclerosis</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>days</b><br><b>year</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature] M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>U25750</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5-5-96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT B. JANCHEZ M.D. 508 Idlewild Ave Easton MD 21601</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 07 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 14973

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HOWARD CORKRAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>16</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>445</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-05-1678</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08/08/08</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Cromwell Center-Genesis Eldercare</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>823 Morris Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21093</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical Engin.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Manufacturing</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard Lee Corkran</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie May Stevens</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nildred A. Corkran</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>823 Morris Avenue Lutherville, MD. 21093</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Veterans Cemetery 4/19/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hurlock, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Williamson Funeral Home<br/>Federalburg, MD. 21632</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 DAYS</b>                                   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  | b. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <b>2 DAYS</b>   |  |
|  |  | c. <b>Alzheimers</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>YEARS</b>  |  |
|  |  | d.   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b><br><b>Renal Insufficiency</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Fredrick Sirkis M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D22645</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/26/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FREDRICK SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 02 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






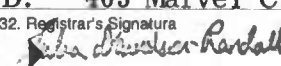
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14974

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |
|--|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARYLEE COLLIER</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>April 27 1996</b>   |  | 3. Time of Death<br><b>8:18 p</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital @ Easton</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>587-44-3170</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. <b>59</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 10, 1936</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Talbot</b>   |  | 10c. City, Town or Location<br><b>McDaniel</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>9072 New Rd.</b>   |   | 10f. Zip Code<br><b>21647</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> Collega (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Quality Control</b>                   |   | 16b. Kind of Business/Industry<br><b>Grayblock Ribbon</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Felgenhouer</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Hause</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald Collier Husband</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9072 New Rd. McDaniel, Maryland 21647</b>  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, funeral home or other place)<br><b>Olivet Cemetery</b>   |   | 20c. Date<br><b>April 30, 1996</b>   |  | 20d. Location - City or Town, State<br><b>St. Michaels, Md. 21663</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Md. 21663</b>                             |   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Adenocystic Carcinoma of the Tongue</b><br>Dua to (or as a consequence of):<br><br>b.<br>Dua to (or as a consequence of):<br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>16 hrs</b> |   |   |   |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                     |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D15135</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/28/96</b> |  |  |   |  |
| 30. Name (and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Fauntleroy M.D. 403 Marvel Ct. Easton, Maryland 21601</b>   |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 1996</b>  |  | 32. Registrar's Signature<br>  |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


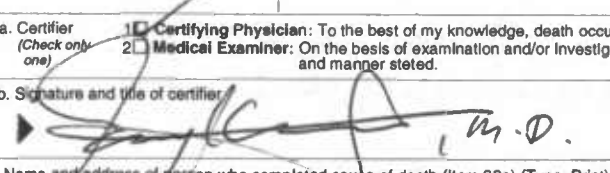
Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14975

Reg. No.

|  |   |  |   |   |  |   |  |  |   |  |  |
|--|---|--|---|---|--|---|--|--|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>MADELINE LANCASTER DAVIS</b>                         |  |   |   |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>6</b> Year <b>1996</b> |  | 3. Time of Death<br><b>17:55P.M.</b>                        |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b> |  |   |   |  |   | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>          |  | 4c. County of Death<br><b>WASHINGTON</b>                    |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>214-09-2872</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 29, 1911</b>        |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |  |
|  | Usual Residence of Decedent   |  |   |   |  |   |  |  |   |  |  |
| 10a. State<br><b>MARYLAND</b>  |   |  | 10b. County<br><b>WASHINGTON</b>  |   | 10c. City, Town or Location<br><b>HAGERSTOWN</b>   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>9946 DOWNSVILLE PIKE</b>  |   |  |   | 10f. Zip Code<br><b>21740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERK</b>   |  |   | 16b. Kind of Business/Industry<br><b>DEPARTMENT STORE</b>          |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN LUTHER LANCASTER</b>  |   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY JULIA HUMPHREY</b>   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JULIA L. LANCASTER</b>  |   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1037 VIEW STREET, HAGERSTOWN, MD. 21742</b> |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>REST HAVEN CEMETERY</b>  |  | Data<br><b>05-10-96</b>   |  | 20c. Location - City or Town, State<br><b>HAGERSTOWN, MARYLAND</b>                                 |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |   |  | 22. Name and Address of Facility<br><b>ANDREW K. COFFMAN FUNERAL HOME, INC.<br/>40 E. ANTIETAM ST., HAGERSTOWN, MD. 21740</b>                   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Sepsis</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>Ruptured diverticulum</b></p> <p>Due to (or as a consequence of):</p> <p>c. <b>Dehydration</b></p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> </div> |   |  |   |   |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>5 Days</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Incontinence</b>  |   |  |   |   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |  |   |   |  |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |  |
|  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br> M.D.  |   |  |   |   |  | 29c. License number<br><b>D-41131</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5-8-96</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JERRY L. CORRECES M.D. 1125 PROFESSIONAL COURT, HAGERSTOWN, MD. 21742</b>   |   |  |   |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 1996</b>  |   |  |   | 32. Registrar's Signature<br>  |  |   |  |  |   |  |  |

To Be Completed by Funeral Director

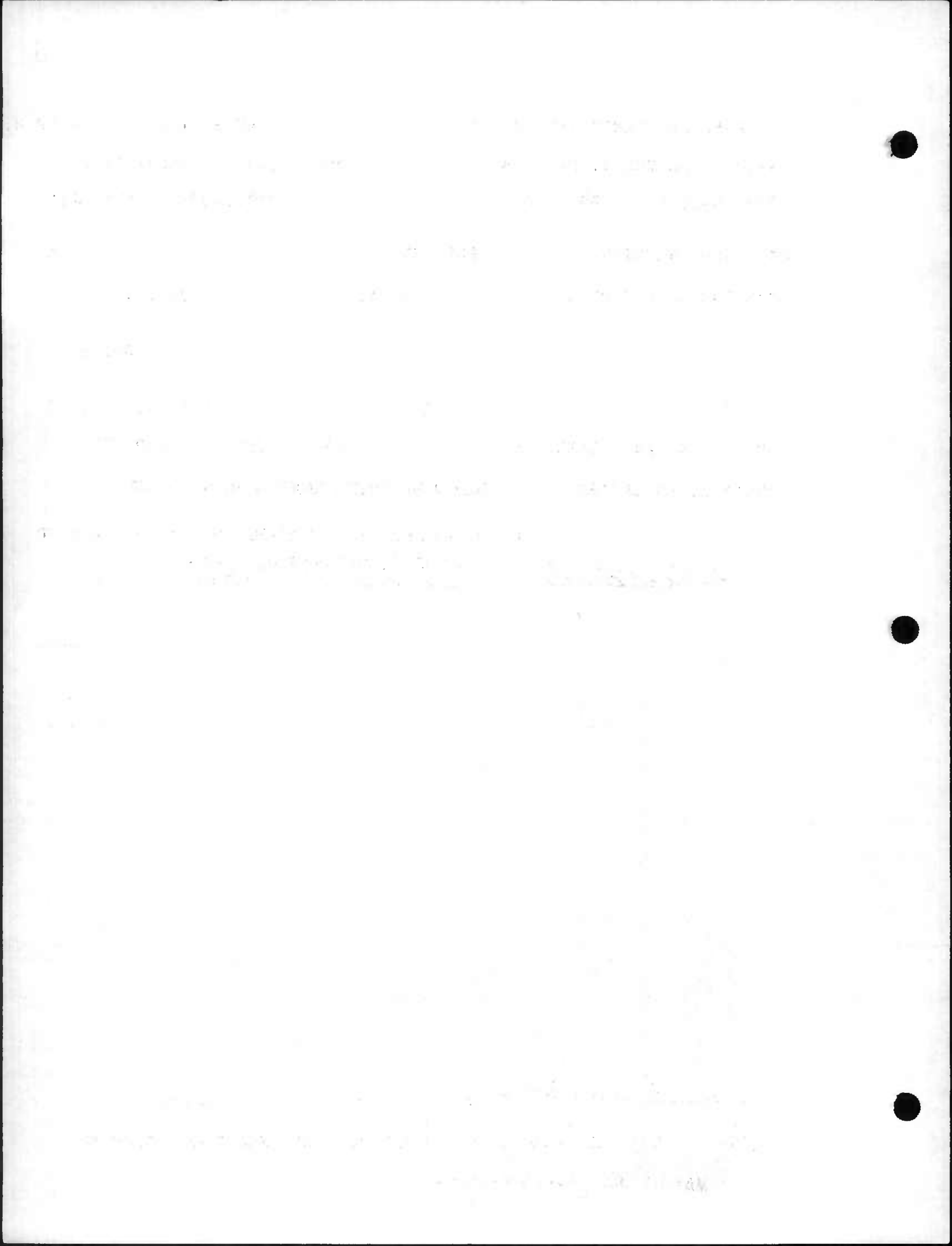
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Amend # 2 Wash. Co. LB May 9, 1996

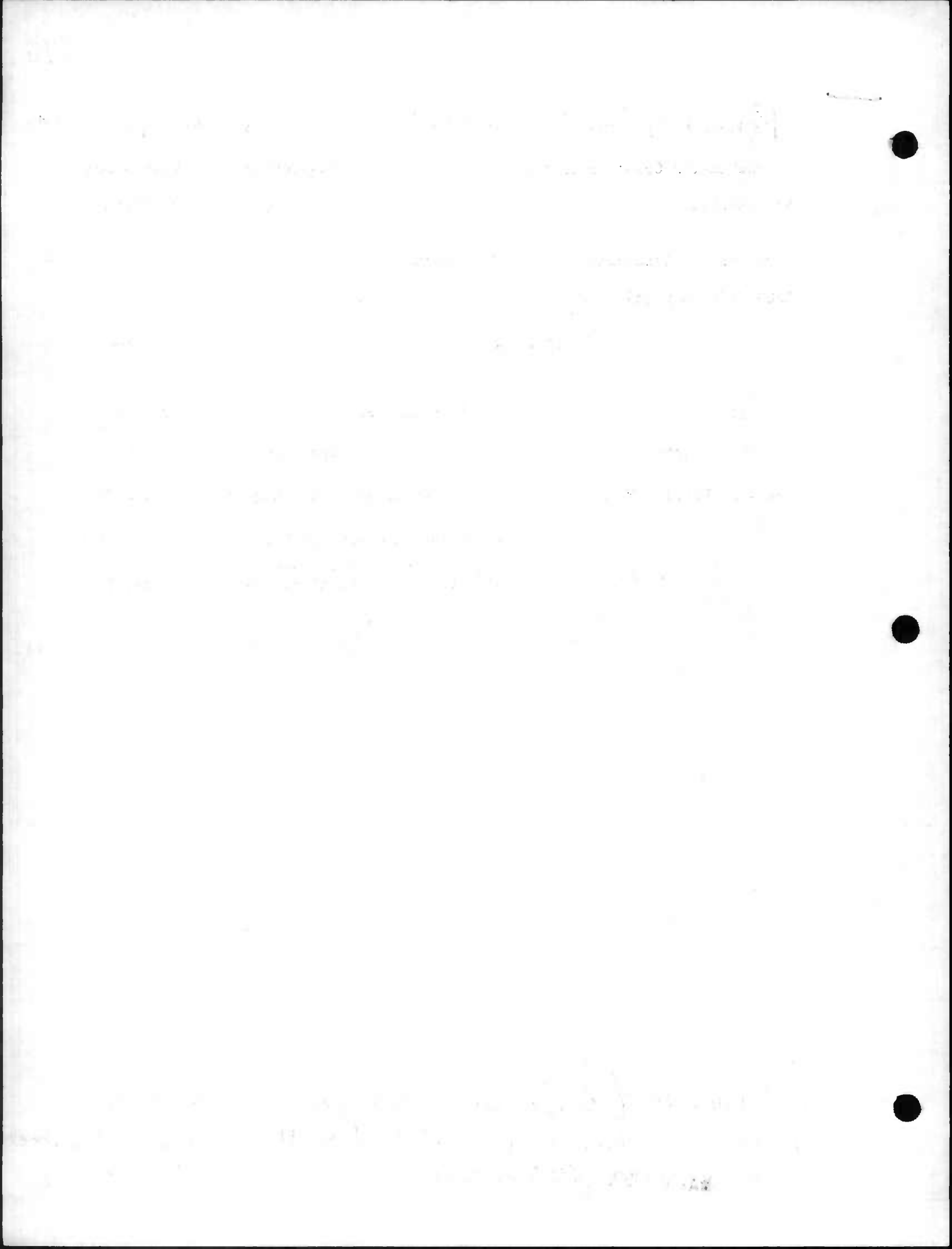
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14976

Certificate of Death

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Franklin Diehl</b>   |  |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> Year <b>96</b>  |  | 3. Time of Death<br><b>8:25 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>516-26-2394</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 16 1929</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Montana</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1308 Jefferson Boulevard</b>   |  | 10f. Zip Code<br><b>21742</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1947-1967</b> |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                              |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrical Sales</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Electrical</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Frank J. Diehl</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Leah Reames</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary R. Diehl / Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1308 Jefferson Blvd. Hagerstown, Md. 21742</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Beaver Creek Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>5/11/96 Hagerstown, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Scott M. Minnich</b>   |  |  |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Carcinoma of Esophagus</b><br>Dua to (or as a consequence of):<br><br>b.<br>Dua to (or as a consequence of):<br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br><b>3 months</b>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>5/11/96</b>   |  |  |  |
|   | 28b. Time of Injury<br><b>M</b>  |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br><b>Frederic H. Kass</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>A23623</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/96</b>  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Frederic H. Kass in MD 1799 Howell Rd Hagerstown Md</b>   |  |  |  | 31. Data filed (Month, Day, Year)<br><b>MAY 09 1996</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>John Anderson-Randall</b>  |  |  |  | 33. Zip Code<br><b>21742</b>  |  |  |  |
|   | State Registrar  |  |  |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

96 14977

Certificate of Death

Reg. No.

Amended # 8.P.6.C. 5-2-96 CE

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

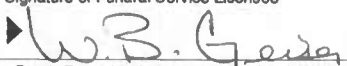
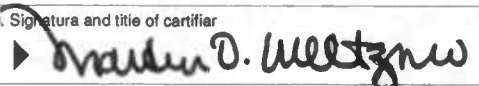

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

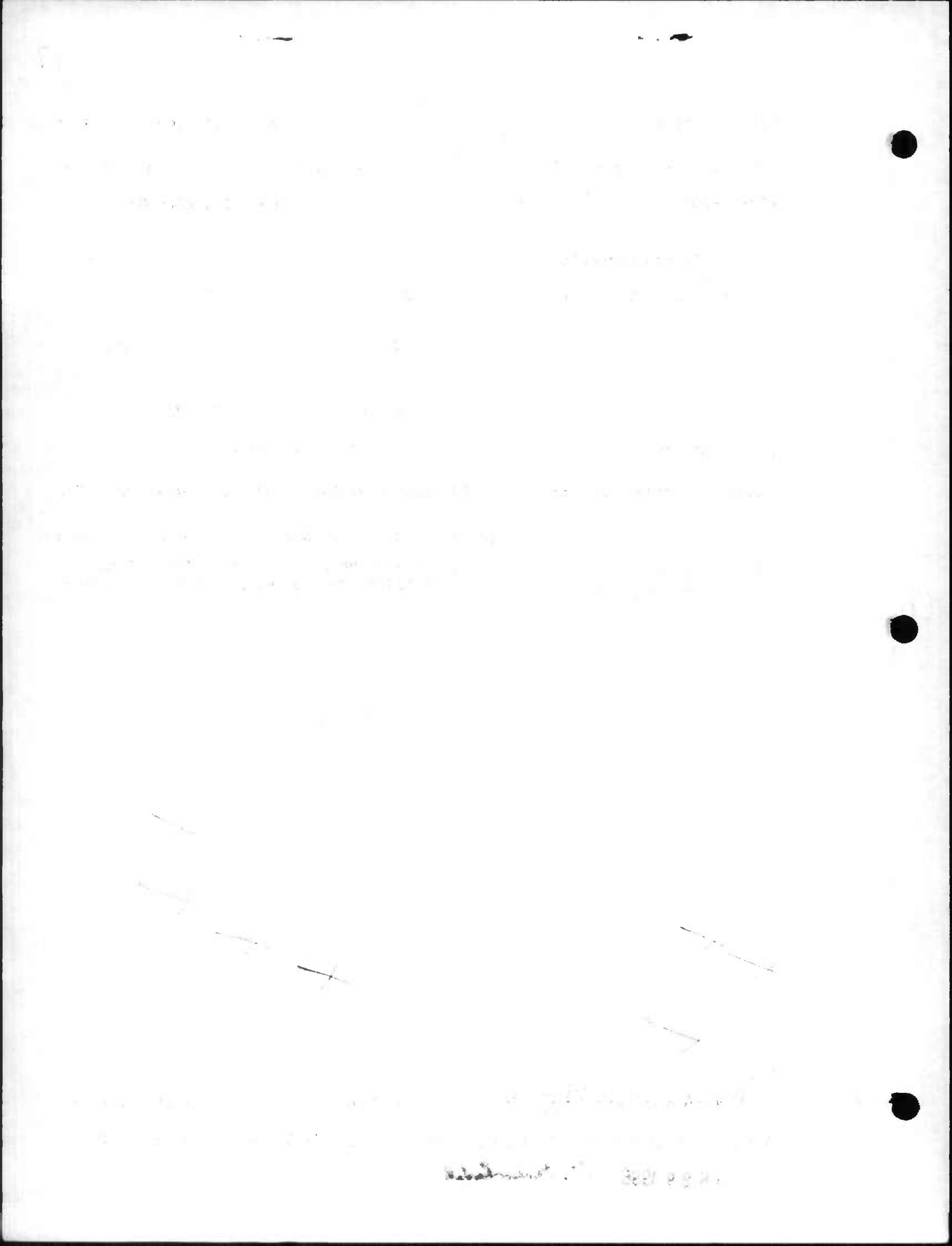
Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>DIANE DEAN  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 27, 1996  |  |   |  | 3. Time of Death<br>7:45 am  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br>7708 Hanover Parkway #102   |  |   |  | 4b. City, Town, or Location of Death<br>Greenbelt   |  |   |  | 4c. County of Death<br>Prince George's   |  |  |  |
| 5. Social Security Number<br>085-32-2057  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>55 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 13, 1949  |  | 9. Birthplace (State or Foreign Country)<br>New York   |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br>MD  |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Greenbelt  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>7708 Hanover Parkway #102   |  |   |  | 10f. Zip Code<br>20770  |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse   |  |   |  | 16b. Kind of Business/Industry<br>Nursing  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Lewis Weisman  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Estelle Scherer  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Danny Earl Dean - Spouse  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7708 Hanover Parkway #102, Greenbelt, MD 20770 |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory 04/28/96   |  | 20c. Location - City or Town, State<br>Alexandria, Virginia   |  |   |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |   |  | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781                     |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cancer of the Ovary<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D23743   |  |   |  | 29d. Date signed (Month, Day, Year)<br>April 27, 1996  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Martin D. Weltz, M.D. 7525 Greenway Center Drive #205, Greenbelt, MD 20770  |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

State  
Registrar






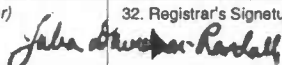
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 14978

Reg. No.

|  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>MARTIN BARRY DALTON</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 23, 1996</b>   |  |  |  | 3. Time of Death<br><b>9:49AM</b>  |  |  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NIH CLINICAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  |  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>520-54-8258</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 1, 1952</b>       |  | 9. Birthplace (State or Foreign Country) New Haven, Connecticut                                     |  |
|  | Usual Residence of Decedent  |  |  |  |   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Illinois</b>  |  | 10b. County<br><b>Madison</b>  |  | 10c. City, Town or Location<br><b>Wood River</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |   |  |
|  | 10e. Street and Number<br><b>217 South 10th Street</b>   |  |  |  | 10f. Zip Code<br><b>62095</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States of America</b>                               |  |  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Viet Nam |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Conductor</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Public Transportation Railroad</b>                        |  |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Carl Anderson</b>  |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>June E. Kecy</b> |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cheryl L. Dalton</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>217 S. 10th Street, Wood River, IL 62095</b>  |  |  |  |  |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Lawn Memory Gardens</b>   |  |  |  | Date<br><b>April 27, 1996</b>  |  | 20c. Location - City or Town, State<br><b>Bethalto, Illinois</b> |  |   |  |
|  | 21. Signature of Funeral Service Licensee #M00690<br>  |  |  |  | 22. Name and Address of Facility<br><b>Marks Mortuary<br/>633 Lorena Avenue, Wood River, IL 62095</b>   |  |  |  |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br><b>b. MULTIORGAN FAILURE</b><br>Due to (or as a consequence of):<br><b>c. METASTATIC MALIGNANT MELANOMA</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |   |  |  |  |  |  |  |  | Approximate interval Between Onset and Death<br><b>12 DAYS</b><br><b>12 DAYS</b><br><b>11 YEARS</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>N/A</b>   |  |  |  |   |  |  |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>N/A</b>   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred                                |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D 29484</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23, 1996</b>     |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT E. CUNNION MD, NIH, BETHESDA MD 20892</b>  |  |  |  |   |  |  |  |  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 30 1996</b>  |  |  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |   |  |

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and the limitations of the study.

5. The fifth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the importance of the research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a glossary. It includes a list of the terms and abbreviations used in the study.

9. The ninth part of the report is a bibliography. It includes a list of the books, articles, and other sources used in the study.

10. The tenth part of the report is a list of the authors and their affiliations.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14979

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Annie Davis</i>   |   | 2. Date of Death<br>Month <i>April</i> Day <i>28</i> Year <i>1996</i> |   | 3. Time of Death<br><i>6:30 AM</i>            |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>1203 Capital View Drive #1732</i> |   | 4b. City, Town, or Location of Death<br><i>Landover</i>               |   | 4c. County of Death<br><i>Prince George's</i> |
| Funeral<br>Director  | 5. Social Security Number<br><i>578-26-2714</i>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>73</i> Yrs.                      | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                |
|  | 8. Date of Birth (Month, Day, Year)<br><i>05-14-22</i>   |   | 9. Birthplace (State or Foreign Country)<br><i>South Carolina</i>     |   |   |
| Usual Residence of Decedent  |  |   |   |   |   |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Prince George's</i>   |   | 10c. City, Town or Location<br><i>Landover</i>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>1203 Capital View Drive #1732</i>  |   | 10f. Zip Code<br><i>20785</i>   |   |
| 10g. Citizen of What Country?<br><i>USA</i>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>1+</i> College (1-4 or 5+) <i>1+</i>  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Housekeeper</i>  |  | 16b. Kind of Business/Industry<br><i>Private</i>  |   | 17. Father's Name (First, Middle, Last)<br><i>Quincy Davis</i>  |   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Rosezellar Akins</i>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Robert Harris/Son</i>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6421 Landover Road, #T3, Landover, MD 20785</i>   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Harmony Memorial Park</i>  |   | 20c. Location - City or Town, State<br><i>Landover, Maryland</i>  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><i>J. B. Jenkins Funeral Home</i><br><i>7474 Landover road, Landover, Maryland 20785</i>  |   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Arteriosclerotic cardiovascular disease</i><br>Due to (or as a consequence of): |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                 |   |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Augusta P. Rodriguez MD</i>   |   | 29c. License number<br><i>D21230</i>  |   |
| 29d. Date signed (Month, Day, Year)<br><i>April 28, 1996</i>   |  | 30. Name and address of person who completed cause of death (from 23e) (Type, Print)<br><i>Augusta P. Rodriguez MD, 5009 Rayburn Ct. C. G. Dr. MD 20748</i>   |   | 31. Date filed (Month, Day, Year)<br><i>MAY 01 1996</i>   |   |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(6)

State  
Registrar



96 14980

1. Decedent's Name (First, Middle, Last) IRENE G. DAWSON 2. Date of Death Month Day Year APRIL 27, 1996 3. Time of Death 12:05 P.M. 4a. Facility Name (If not institution, give street and number) 5937 BONIWOOD TURN 4b. City, Town, or Location of Death CLINTON 4c. County of Death PRINCE GEORGES 5. Social Security Number 578-70-0300 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 45 8. Date of Birth (Month, Day, Year) JAN 21, 1951 9. Birthplace (State or Foreign Country) Wash., D.C. 10a. State MD. 10b. County PRINCE GEORGES 10c. City, Town or Location CLINTON 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 5937 E. BONIWOOD TURN 10f. Zip Code 20735 10g. Citizen of What Country? UNITED STATES 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 12 16. Kind of Business/Industry F.D.I.C. 17. Father's Name (First, Middle, Last) WILLIAM GILLISON 18. Mother's Name (First, Middle, Maiden Surname) EVA PORTER 19a. Informant's Name/Relationship (Type, Print) FRANK A. VINCENT /POWER ATT. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5937 E. BONIWOOD TURN, CLINTON, MARYLAND 20735 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20c. Location - City or Town, State Alexandria, VA 21. Signature of Funeral Service Licensee Alex S. Pope Jr. M859 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD. 20747 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D19431 29d. Date signed (Month, Day, Year) April 29, 1996 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. FRANK M. RYAN, MD FACP 6188 OXON HILL RD STE 601 OXON HILL, MD 20745 31. Date filed (Month, Day, Year) MAY 02 1996 32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene

96 14981

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |   |  |  |  |  |
|---|---|---|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>DARRELL ANTHONY DiLallo   |   |  |  | 2. Date of Death<br>Month Day Year<br>April 29, 1996   |   | 3. Time of Death<br>10:14  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |   |  |  | 4b. City, Town, or Location of Death<br>SALISBURY  |   | 4c. County of Death<br>WICOMICO  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>331-38-5810  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>50 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>April 18, 1946                                |  | 9. Birthplace (State or Foreign Country)<br>Illinois   |  |
|   | Usual Residence of Decedent   |   |  |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |   | 10b. County<br>Wicomico  |  | 10c. City, Town or Location<br>Salisbury   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>6426 Centennial Drive   |   |  |  | 10f. Zip Code<br>21801   |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Army   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Executive   |   |  | 16b. Kind of Business/Industry<br>Date Processing  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Oscar Guy Di Lallo   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Irene Frances Cys   |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Irene C. Di Lallo/mother  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6426 Centennial Drive, Salisbury, MD 21801  |   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Salisbury Crematory  |   | Date<br>5/3/96   |  | 20c. Location - City or Town, State<br>Salisbury, MD   |  |
|   | 21. Signature of Funeral Service Licensee<br>David H. Thompson  |   |  |  | 22. Name and Address of Facility<br>Holloway Funeral Home<br>501 Snow Hill Rd., Salisbury, MD 21804  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>SUDDEN CARDIAC ARREST</u><br>Due to (or as a consequence of):<br>b. <u>Probable Ruptured Aortic Aneurysm</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>30 MIN<br>4 hours |   |  |  |  |   |  |  |  |  |
|   | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DIABETES</u> |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  |  |   |  |  |  |  |
|   | 29b. Signature and title of certifier<br>Ronald P. Travitz  |   |  |  | 29c. License number<br>D36576  |   | 29d. Date signed (Month, Day, Year)<br>4/29/96                                       |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RONALD P. TRAVITZ MD 560 Riverside Dr SALIS   |   |  |  |  |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAY 02 1996  |   | 32. Registrar's Signature<br>John Andrew Randall   |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 14982

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frances June Drews

2. Date of Death

May  
05

Day

Year

3. Time of Death

9:30 am

4a. Facility Name (If not institution, give street and number)

3900 Ravine Drive

4b. City, Town, or Location of Death

White Plains

4c. County of Death

Charles

5. Social Security Number

543-36-7717

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Mar. 26, 1933

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

White Plains

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3900 Ravine Drive

10f. Zip Code

20695

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Michael Dempsey

16. Mother's Name (First, Middle, Maiden Sumame)

Geraldine Brown

19a. Informant's Name/Relationship (Type, Print)

Kenneth E. Drews

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3900 Ravine Drive, White Plains, MD 20695

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Cemetery

Date

5-13-96

20c. Location - City or Town, State

Holly, Colorado

21. Signature of Funeral Service Licensee

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home, Inc.

P. O. box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PRIMARY BRAIN CANCER.

Due to (or as a consequence of):

Approximate interval Between Onset and Death

8 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kenneth M. Mathur

29c. License number

028352

29d. Date signed (Month, Day, Year)

5-6-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Krishan Mathur P.O. Box 2729, La Plata, Md. 20646

31. Date filed (Month, Day, Year)

MAY 08 1996

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14983

amended item #4, BJV, Talbot Co., 05/10/96

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH B. DODA</b>  |  |   |  | 2. DATE OF DEATH<br><b>MAY 3, 1996</b> YEAR   |  | 3. TIME OF DEATH<br><b>10:45P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-22-6679</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>APR. 29, 1927</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>14147 OLD WYE MILLS ROAD</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WYE MILLS</b>   |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>  |   |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>TALBOT</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WYE MILLS</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>14147 OLD WYE MILLS ROAD</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21679</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (13-16) <b>2</b> or 5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMMETT A. BARTON</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARA CANNON</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ALBERT R. DODA, JR.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>613 ECHO COVE DRIVE, CROWNSVILLE, MD. 21032</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.)<br><b>ST. PETER'S CEMETERY</b>   |  | 20c. DATE<br><b>5-7</b>   |  | 20d. LOCATION — City or Town, State<br><b>QUEENSTOWN, MARYLAND</b>                          |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M. E. Newnam III C.F.S.P.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM<br/>200 S. HARRISON ST., EASTON, MD. 21601</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>5 months</b>                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>041339</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5-7-96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMIE HARRIS JR. / 102 E. MAIN ST. STEVENSVILLE, MD 21661</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 07 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14984

## Certificate of Death

Reg. No.

|  |  |  |   |                                 |   |
|--|--|--|---|---------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Virginia Louise Davis</i>   |  | 2. Date of Death<br>Month <i>May</i> Day <i>1</i> Year <i>1996</i>  |                                 | 3. Time of Death<br><i>1028</i>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |                                 | 4c. County of Death<br><b>WICOMICO</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>228-28-6411</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 29, 1926</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |                                 |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  | 10c. City, Town or Location<br><b>Berlin</b>  |                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Worcester</b>  |   |                                 |   |
|  | 10e. Street and Number<br><b>5 Hickory Way, Ocean Pine</b>   |  | 10f. Zip Code<br><b>21811</b>   |                                 | 10g. Citizen of What Country?<br><b>United States</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                           |                                 |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Payroll Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Dept. Store</b>  |                                 |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Wesley Green</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Cloud</b>  |                                 |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Rae Muhlberg</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2161 Gladdings Court, Waldorf, Maryland 20601</b> |                                 |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery May 4, 1996</b>                                      |                                 | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735</b>                                      |                                 |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiorespiratory failure</b><br>Due to (or as a consequence of):<br><b>b. perforated small bowel</b><br>Due to (or as a consequence of):<br><b>c. metastatic breast cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                 | Approximate Interval Between Onset and Death<br><b>24 hr</b><br><b>24 hr</b><br><b>15 mo</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                 | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                 |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                 |   |
| State Registrar  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D44979</b>  |                                 | 29d. Date signed (Month, Day, Year)<br><b>5/11/96</b>   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Janet Wasson MD 145 E. Carroll St. Salisbury Md.</b>  |  |   |                                 |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 08 1996</b>              |  | 32. Registrar's Signature<br><i>[Signature]</i>                            |   |                                 |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14985

Amended #1,5/6/96,PCT,Howard

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |   |  |
|--|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last) <u>Richard T. Engles</u>   |   |  |  | 2. Date of Death<br>Month <u>May</u> Day <u>04</u> Year <u>1996</u>  |   | 3. Time of Death<br><u>4:30 PM</u>                                      |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><u>Howard County General Hospital</u>   |   |  |  | 4b. City, Town, or Location of Death<br><u>Columbia</u>  |   | 4c. County of Death<br><u>Howard</u>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-05-4306</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><u>Oct 1, 1921</u>               |  |
|  | 9. Birthplace (State or Foreign County)<br><u>Maryland</u>  |   | 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Howard</u>   |   | 10c. City, Town or Location<br><u>Ellicott City</u>                     |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><u>3417 Font Hill Drive</u>  |  | 10f. Zip Code<br><u>21042</u>  |   | 10g. Citizen of What Country?<br><u>United States</u>                   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>1942-45</u> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Inspector</u>                                    |  | 16b. Kind of Business/Industry<br><u>State Government</u>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Elmer Engles</u>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><u>Blanche Amelia Lupus</u>   |   |   |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><u>Mrs. Jacklyn Myers/Niece</u>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3457 Baker Road Westminster, Maryland 21157</u>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Loudon Park Cemetery</u>  |  | Date<br><u>5-8-96</u>  |   | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>       |  |
|  | 21. Signature of Funeral Service Licensee<br><u>Shirley Collins-Witzke</u>  |   |  |  | 22. Name and Address of Facility<br><u>Harry H. Witzke Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</u>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <u>CORONARY ARTERY DISEASE</u><br>Due to (or as a consequence of):<br>b. <u>CARDIAC ARREST ASYSTOLE, Sudden</u><br>Due to (or as a consequence of):<br>c. <u>Ventricular Arrhythmia</u><br>Due to (or as a consequence of):<br>d. <u>DEATH</u> |   |  |  |  |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Active Post-Transfusion Hepatitis C</u>   |   |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D19510</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>May 5th 1996</u>                                  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>A. DIVAKARAN, MD, 10806</u>   |   | <u>HICKORY RIDGE ROAD COLUMBIA, MD 21044</u>  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAY 06 1996</u>  |   | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14986

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |   |  |   |  |
|--|---|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALLAN RICHARD EBERLE  |   |   |  | 2. Date of Death<br>Month Day Year<br>April 30, 1996   |   | 3. Time of Death<br>12:55 am                                     |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital   |   |   |  | 4b. City, Town, or Location of Death<br>Olney  |   | 4c. County of Death<br>Montgomery                                |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-09-2301  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>March 16, 1915  | 9. Birthplace (State or Foreign Country)<br>Maryland             |   |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  | 10b. County<br>Montgomery   | 10c. City, Town or Location<br>Silver Spring  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        |  |   |  |
|  | 10e. Street and Number<br>15100 Interlachen Drive   |   |   | 10f. Zip Code<br>20906   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941-42 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)<br>3   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Chemist                                   |  |  | 16b. Kind of Business/Industry<br>Federal Government  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Henry A. Eberle  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alta Cramer   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Lucille Eberle - Spouse   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15100 Interlachen Drive, Apt. #206, Silver Spring, MD |  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |  | Date<br>05/03/96   |   | 20c. Location - City or Town, State<br>Brentwood, Maryland       |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781                            |  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Respiratory Failure</u><br>Due to (or as a consequence of):<br>b. <u>COPD (Chronic Obstructive Pulmonary Disease)</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |  | 28d. Describe how Injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and Title of certifier<br>   |   | 29c. License number<br>023459  |  | 29d. Date signed (Month, Day, Year)<br>5/2/96 May 2, 1996   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Edward P. Taubman, M.D. 18111 Prince Phillip Drive #T-12, Olney, MD 20832  |   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 03 1996   |   | 32. Registrar's Signature<br>   |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



96 14987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Marie Belle Funk</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>May 8 1996</i>   |  | 3. TIME OF DEATH<br><i>8:10 P.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-16-0904</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>74</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Aug. 5, 1921</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>22240 Jefferson Blvd.</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Smithsburg</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  |   |  | 10b. COUNTY<br><i>Washington</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Smithsburg</i>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><i>22228 Jefferson Blvd.</i>  |  |  |  |
| 10f. ZIP CODE<br><i>21783</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>H. Henry Hill</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Hazel Scott</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Robert L. Funk</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>22228 Jefferson Blvd. Smithsburg, Md. 21783</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Beaver Creek Cemetery May 11, 96</i>  |  | 20c. LOCATION — City or Town, State<br><i>Beaver Creek Md.</i>  |  | 20d. NAME AND ADDRESS OF FACILITY<br><i>12525 Bradbury Ave.<br/>Davis Funeral Home Smithsburg, Md. 21783</i> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Davis</i>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of breast</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frederick H. Cass III MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D23623</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>5/10/96</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Frederick H. Cass III MD 1798 Howell Rd Hagerstown Md</i>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAY 10 1996</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davis</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN WILLIE FREEMAN</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 24 1996</b>  |  | 3. Time of Death<br><b>5:30 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| 5. Social Security Number<br><b>249-48-9815</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>NOV. 27, 1932</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>LAURENS COUNTY, SC</b>   |  |   |  |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>UPPER MARLBORO</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>12805 WINONA DRIVE</b>   |  | 10f. Zip Code<br><b>20774</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MEATCUTTER</b>   |  | 16b. Kind of Business/Industry<br><b>PVT.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>CLYDE FREEMAN, SR.</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>ROSA GRAY</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ANNE FREEMAN/ WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12805 WINONA DRIVE UPPER MARLBORO, MD 20774</b> |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>4-29-96 LANDOVER, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Juanana L. Braxton</i>   |  | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME</b><br><b>4308 SUITLAND ROAD SUITLAND, MARYLAND 20746</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Infarct, Right Frontal-Parietal Brain</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |  | Approximate Interval Between Onset and Death<br><b>days</b>   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Diabetes Mellitus</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>J. Berger MD</i>  |  | 29c. License number<br><b>D25925</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>April 26, 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. BERGER MD #205, 7720 WISCONSIN Ave, Bethesda, Md 20814</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |  | 32. Registrar's Signature<br><i>John R. Randall</i>   |  |   |  |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14989

## Certificate of Death

Reg. No.

|   |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
|---|---|--|--|---|---|--------------------------|--------------------------------|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Laura Foggie</i>                           |  |  |   | 2. Date of Death<br>Month <i>April</i> Day <i>21</i> Year <i>1996</i> |                          |                                |  | 3. Time of Death<br><i>12:45 AM</i>    |   |   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1868 Addison Road South |  |  |   | 4b. City, Town, or Location of Death<br>District Heights              |                          |                                |  | 4c. County of Death<br>Prince George's |   |   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-32-3816  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>104 Yrs.                            |                          | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.         |   | 8. Date of Birth (Month, Day, Year)<br>May 23, 1891 |  | 9. Birthplace (State or Foreign Country)<br>Westmoreland, VA |  |
|   | Usual Residence of Decedent   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 10a. State<br>Maryland  |   |  |  | 10b. County<br>Prince George's  |   |                          |                                | 10c. City, Town or Location<br>District Heights  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1868 Addison Road South   |   |  |  | 10f. Zip Code<br>20747  |   |                          |                                | 10g. Citizen of What Country?<br>United States   |  |   |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |                          |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>3 years  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cafeteria Worker   |   |                          |                                | 16b. Kind of Business/Industry<br>Government   |  |   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Samuel Thompson  |   |  |  |   |   |                          |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucy Gaskins  |  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert T. Moore - Son   |   |  |  |   |   |                          |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10710 Valley Brook Dr. Ft. Washington, MD 20744   |  |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Memorial Cemetery   |   |                          |                                | Date<br>4/26/96  |  | 20c. Location - City or Town, State<br>Suitland, Maryland |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Shirley Stewart III</i>   |   |  |  | 22. Name and Address of Facility<br>Stewart Funeral Home<br>4001 Benning Road, N.E. Washington, D.C. 20019  |   |                          |                                |  |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Myocardial infarction secondary to atherosclerotic cardiovascular disease</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                          |                                |  |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                         |   |  |  |  |
|   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                          |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  | 29b. Signature and title of certifier<br><i>Augusto P. Rodriguez MD</i>   |   |                          |                                | 29c. License number<br>D 212 30  |  |   |   | 29d. Date signed (Month, Day, Year)<br>April 22, 1996  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Gp. Apr. Md 20742</i>  |   |  |  |   |   |                          |                                |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 1996  |   |  |  | 32. Registrar's Signature<br><i>John Andrew Carroll</i>   |   |                          |                                |  |  |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 4025.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we consider the case of a single particle.

3. The third part is devoted to the case of a system of particles.

4. In the fourth part, we consider the case of a continuous medium.

5. The fifth part is devoted to the case of a system of continuous media.

6. In the sixth part, we consider the case of a single continuous medium.

7. The seventh part is devoted to the case of a system of continuous media.

8. In the eighth part, we consider the case of a single continuous medium.

9. The ninth part is devoted to the case of a system of continuous media.

10. In the tenth part, we consider the case of a single continuous medium.

11. The eleventh part is devoted to the case of a system of continuous media.

12. In the twelfth part, we consider the case of a single continuous medium.

13. The thirteenth part is devoted to the case of a system of continuous media.

14. In the fourteenth part, we consider the case of a single continuous medium.

15. The fifteenth part is devoted to the case of a system of continuous media.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14990

## Certificate of Death

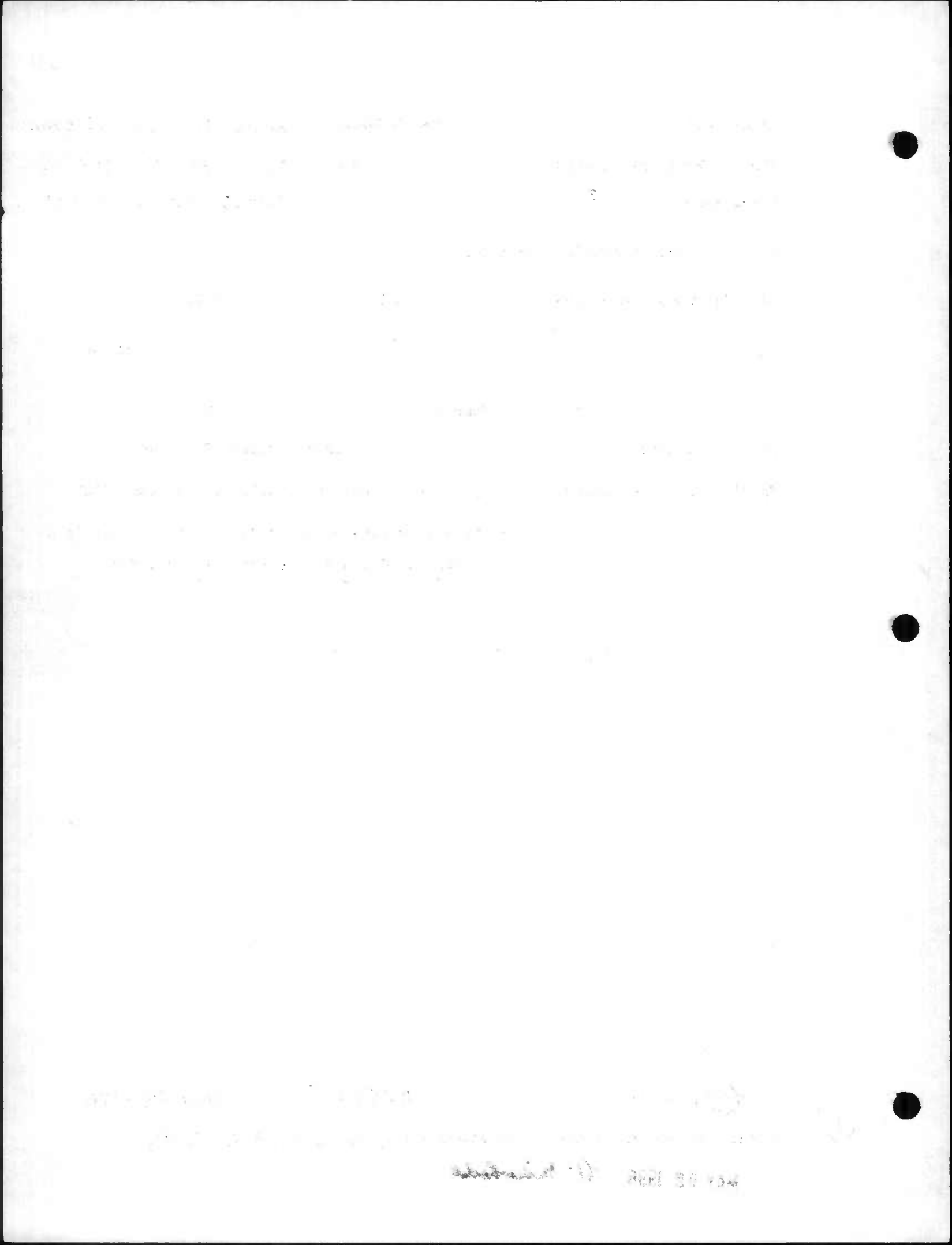
Reg. No.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET</b>   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>30</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2:00 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2702 Kirkwood Place #203</b>   |   | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>  |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-26-3504</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>July 23, 1930</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  |  |
|   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Prince George's</b>   | 10c. City, Town or Location<br><b>Hyattsville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>2702 Kirkwood Place #203</b>   |   | 10f. Zip Code<br><b>20782</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clinton W. Davis</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Warner Tomlinson</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Marcus - Sister</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7314 24th Avenue, Hyattsville, Maryland 20783</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>05/03/96 Brentwood, Maryland</b>                     |
|   | 21. Signature of Funeral Service Licensee<br><b>Francis Gasch - Brady</b>   |   | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>                   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Hypertensive Cardio-vascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   |  |  |
| 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Berger MD</b>   |   | 29c. License number<br><b>D 25925</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. BERGER #205, 7720 WISCONSIN Ave, Bethesda, Md 20814</b>   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 1996</b>   |   | 32. Registrar's Signature<br><b>J. Berger</b>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 14991

## Certificate of Death

Reg. No.

|  |  |  |   |                                |   |  |  |  |
|--|--|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Blanche Faust Franklin   |  |   |                                | 2. Date of Death<br>Month Day Year<br>April 26, 1996  |  | 3. Time of Death<br>1:00 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Larkin Chase Nursing Home  |  |   |                                | 4b. City, Town, or Location of Death<br>Bowie   |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director  | 5. Social Security Number<br>349-30-5644   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>90 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Oct. 14, 1905   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |
|  | Usual Residence of Decedent  |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD   | 10b. County<br>Prince George's   | 10c. City, Town or Location<br>Cheverly   |                                |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>3107 Crest Avenue  |  |   | 10f. Zip Code<br>20785         |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Librarian                                |                                | 16b. Kind of Business/Industry<br>Hyattsville   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>William Faust   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Yeakel   |  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>William R. Franklin / Son  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>136 Bay Drive, Stevensville, Maryland 21666  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>German Protestant Cemetery  |                                | 20c. Location - City or Town, State<br>Mahoney City, PA   |  | 20d. Date<br>04/29/96  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |                                | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Ave., Hyattsville, MD 20781   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br>b. STROKE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>21-Y. |  |   |                                |   |  |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus   |  |   |                                |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |                                | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
|  | 28a. Date of Injury (Month, Day Year)  |  |   |                                | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred  |  |   |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| State Registrar  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                | 29b. Signature and title of certifier<br>   |  |  |  |
|  | 29c. License number<br>D-34525   |  |   |                                | 29d. Date signed (Month, Day, Year)<br>04-26-96   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>S.J. Rao, MD - 4000 Mitchellville Road, #220, Bowie, MD - 20716  |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996                     |  |  |   | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



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State of Maryland / Department of Health and Mental Hygiene

96 14992

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |  |   |  |
|---|--|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ellis Henry Frazier</b>   |  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>May 2, 1996</b>   |  | 3. Time of Death<br><b>11:15 P</b>   |   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Fort Washington Hospital</b>  |  |   |   |  | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>   |  | 4c. County of Death<br><b>Prince George</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-16-2402</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 13, 1916</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George</b>   |   | 10c. City, Town or Location<br><b>Fort Washington</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>3604 Chandler Drive</b>   |  |   |   | 10f. Zip Code<br><b>20744</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                            |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b> |  |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>                        |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Henry Frazier</b>  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Molly Shands</b>   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Golden</b>   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3604 Chandler Drive, Fort Washington, Md 20744</b> |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>                        |  |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>                                     |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cardiorespiratory arrest</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes mellitus</b><br>Due to (or as a consequence of):<br>c. <b>Arteriosclerosis</b><br>Due to (or as a consequence of):<br>d. |  |   |   |  |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D09162</b>                        |  |
| 29d. Date signed (Month, Day, Year)<br><b>May 3, 1996</b>   |  |  |   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jafar Nazemian, M.D.</b><br><b>Oxon Hill, Maryland</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 08 1996</b>     |  |
| 32. Registrar's Signature<br>  |  |  |   |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14993

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |  |
|---|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELMER MARSHALL GREGORY</b>   |   |   |   | 2. Date of Death<br>Month <b>5</b> Day <b>9</b> Year <b>96</b>   |  | 3. Time of Death<br><b>5:30 PM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>MAJOR CARE RUTON</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTO.</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>233-30-6571</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 16, 1920</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>Finksburg</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>2348 Sandymount Road</b>   |   | 10f. Zip Code<br><b>21048</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>carpenter</b>                                 |   | 16b. Kind of Business/Industry<br><b>carpentry</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Hillary F. Gregory</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie May Miller</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Katherine Eileen Gregory, wife</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2348 Sandymount Road, Finksburg, MD 21048</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sandymount Church Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Finksburg, MD</b>  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Katherine Eileen Gregory - Sweitzer</b>   |   | 22. Name and Address of Facility<br><b>Price's Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>                                    |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CUA</b><br>Due to (or as a consequence of):<br>b. <b>ASCVD</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>years</b><br><b>years</b>  |   |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how Injury occurred                     |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner  |   | 29b. Signature and title of certifier<br><b>John A. Henderson</b>   |   |   |  |  |  |  |
|   |   | 29c. License number<br><b>D-12950</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/10/96</b> |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES A. GUINER, MD 7801 YORK RD TOWSON MD 21204</b>   |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 1996</b>   |   | 32. Registrar's Signature<br><b>John A. Henderson</b>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 14994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Annie Veronica GRUBER  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>May 4, 1996   |  | 3. TIME OF DEATH<br>6:25 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>182-14-8555   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 30, 1920                                 |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Ravenwood Lutheran Village   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania                             |   |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Williamsport  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>8 S. Conococheague St.  |  |  |   |
| 10f. ZIP CODE<br>21795   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>5   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Clayton Estep   |  |   |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Elizabeth Edwards   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helen V. Burkett   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13614 Broadfording Church Rd. Hagerstown, MD 21740   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenlawn Memorial Park  |  | DATE<br>5/7   |  | 20c. LOCATION — City or Town, State<br>Williamsport, MD 21740                        |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOME<br>P.O. Box # 348 Williamsport, MD 21740   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cerebrovascular Stroke</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br>14 days   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Progressive heart failure, chronic renal failure, Diabetes mellitus, Hypertension</u>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 26d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>SAMUEL CHAN   |  |   |  | 29c. LICENSE NUMBER<br>D36055   |  | 29d. DATE SIGNED (Month, Day, Year)<br>5/5/96  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>1185 MT AETNA RD. Hagerstown, MD 21740   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAY 06 1996   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson-Rodolph  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amend # 2015 Wash. Co. LB. 05-09-96 96 14995

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |                                   |   |  |   |  |
|--|--|---|--|--|--|---|-----------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mabel Ruth GARVER  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>May 05 1996  |  | 3. TIME OF DEATH<br>8:40 a.m. M                                     |                                   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-74-0899   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>101 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 29, 1894            |                                   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Avalon Manor Home, Inc.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |   | 9c. COUNTY OF DEATH<br>Washington |   |  |   |  |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Washington  |  | 10c. CITY, TOWN OR LOCATION<br>Smithsburg                           |                                   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>Main Street  |  |   |  | 10f. ZIP CODE<br>21783   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                |                                   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white |                                   |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>her own                           |                                   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Rehman Miller   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Jennie Harbaugh   |  |   |                                   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mildred R. Pryor   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Box 231, Smithsburg, Md. 21783  |  |   |                                   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery 5-8-96                                       |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland  |  |   |                                   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnick</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740   |  |   |                                   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma in situ</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |  |  |   |                                   | Approximate Interval Between Onset and Death<br><i>2</i>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cardiovascular Accident Anemia</i><br><i>Hypertensive seizure disorder</i>  |  |   |  |  |  |   |                                   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |   |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br>M  |                                   | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 26d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  |   |  | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                   | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |                                   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. V. Datta</i>   |  |   |  |  |  | 29c. LICENSE NUMBER<br>D18017                                       |                                   | 29d. DATE SIGNED (Month, Day, Year)<br>May 6, 1996  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. V. Datta, 334 Mill St., Hagerstown, Md. 21740   |  |   |  |  |  |   |                                   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAY 06 1996   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. B. Dutton</i>   |  |   |                                   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 14996

Reg. No.

|  |   |                                  |   |  |   |  |  |   |   |  |
|--|---|----------------------------------|---|--|---|--|--|---|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Sandra Barbara Golding</b>                           |                                  |   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2:20PM</b>                             |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b> |                                  |   |  |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>                      |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>118-34-5892</b>   |                                  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F<br><b>XX</b>   | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 23, 1944</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |  |
|  | Usual Residence of Decedent   |                                  |   |  |   |  |  |   |   |  |
| 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Washington</b> |   | 10c. City, Town or Location<br><b>Hancock</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
| 10e. Street and Number<br><b>205 Fulton St.</b>  |   |                                  |   |  | 10f. Zip Code<br><b>21750</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |   |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Service Representative</b> |   |  | 16b. Kind of Business/Industry<br><b>Banking</b>   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Donald Buongiorno</b>   |   |                                  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucille Marie Rocco</b>   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles V. Golding/ Husband</b>   |   |                                  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 Fulton St. Hancock, Md. 21750</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |  |   | Data<br><b>5/8/96</b>  |  | 20c. Location - City or Town, State<br><b>Hagerstown, Md.</b> |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                  |   |  | 22. Name and Address of Facility<br><b>Burner Trade Services<br/>1037 Dual Pl. Hagerstown, Md. 21740</b>  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>NON-SMALL CELL LUNG CARCINOMA</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p><b>6 MONTHS</b></p> </div> </div> |   |                                  |   |  |   |  |  |   |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                  |   |  |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |                                  |   |  |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                                  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                  | 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br><b>D38892</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/7/96</b>          |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAMELA FOX BRADFORD, MD 1799 HOWELL RD. HAGERSTOWN, MD 21740</b>  |   |                                  |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 08 1996</b>  |   |                                  | 32. Registrar's Signature<br>   |  |   |  |  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14997

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |   |
|--|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>AURELIA C. GEORGE</b>   |   |  |  | 2. Date of Death<br>Month <b>04</b> Day <b>26</b> Year <b>1996</b> |  | 3. Time of Death<br><b>2300</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRESIDENTIAL WOODS HEALTH CARE FACILITY</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>ADAPPHI, MD</b>         |  | 4c. County of Death<br><b>PR. GEORGES</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>518-42-5762</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>                   | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>   | 8. Date of Birth (Month, Day, Year)<br><b>5/12/16</b>  | 9. Birthplace (State or Foreign Country)<br><b>WASH. D.C.</b>           |
|  | Usual Residence of Decedent  |   |  |  | 10c. City, Town or Location<br><b>WASHINGTON, D.C.</b>             |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. State   |  | 10b. County   |  | 10f. Zip Code<br><b>20012-2657</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 10e. Street and Number<br><b>723 WHITTIER STREET N.W.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business/Industry<br><b>HOMEMAKER</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT C. CARTER</b>   |  |   |
| 17. Mother's Name (First, Middle, Maiden Surname)<br><b>MABEL NEILSON</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JOHN T. GEORGE (SPOUSE)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS 10e</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>SUITLAND, MD.</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>TAKOMA FUNERAL HOME INC 254 CARROLL ST. N.W. WASHINGTON, D.C. 20012</b>   |  |   |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPERTENSION.</b><br>Due to (or as a consequence of):<br><b>b. RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>c. Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><b>d. Respiratory failure.</b> |  | Approximate Interval Between Onset and Death<br><b>&gt; Years.</b><br><b>&gt; 12 months</b><br><b>&gt; 12 months</b><br><b>&gt; 2 months</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 24f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pls. Aspiration Pneumonia.</b><br><b>Congestive Heart failure.</b> |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |  | 28b. Time of Injury<br><b>N/A</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |
| 29b. Signature and title of certifier<br><br><b>RAMON R. TULI</b>  |  | 29c. License number<br><b>D19609.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4.27.96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAMAN R. TULI 3503 PERRY ST. #B, MT. RAINIER, MD. 20712-2141</b>  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |  | 32. Registrar's Signature<br>   |  | 33. Registrar's Title<br><b>John Anderson</b>  |  | 34. Registrar's Address<br><b>3503 PERRY ST. #B, MT. RAINIER, MD. 20712-2141</b>   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 14998

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louisly Garner

2. Date of Death

Month Day Year  
April 25, 1996

3. Time of Death

10:05 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Carroll Manor Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

578-32-1462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 3, 1908

9. Birthplace (State or Foreign Country)

Spartenbuth, SC

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

District of Columbia

Washington

1 ☒ Yes 2 ☐ No

10e. Street and Number

401 K Street, N. W. #328

10f. Zip Code

20001

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Clarence Garner

18. Mother's Name (First, Middle, Maiden Surname)

Lelia Murph

19a. Informant's Name/Relationship (Type, Print)

Shirley W. Inniss

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4604 Easy Place, S. E., Washington, D. C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

4/30/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Cardiac arrest

Due to (or as a consequence of):

b.

Metastatic Lung Cancer.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Meersaid Zanczi M.D.

29c. License number

12391 D.C.

29d. Date signed (Month, Day, Year)

4-25-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meersaid Zanczi M.D. 1328 Southern Ave SE #307 Washington D.C.

31. Date filed (Month, Day, Year)

APR 30 1996

32. Registrar's Signature

John T. Stewart III

State  
Registrar

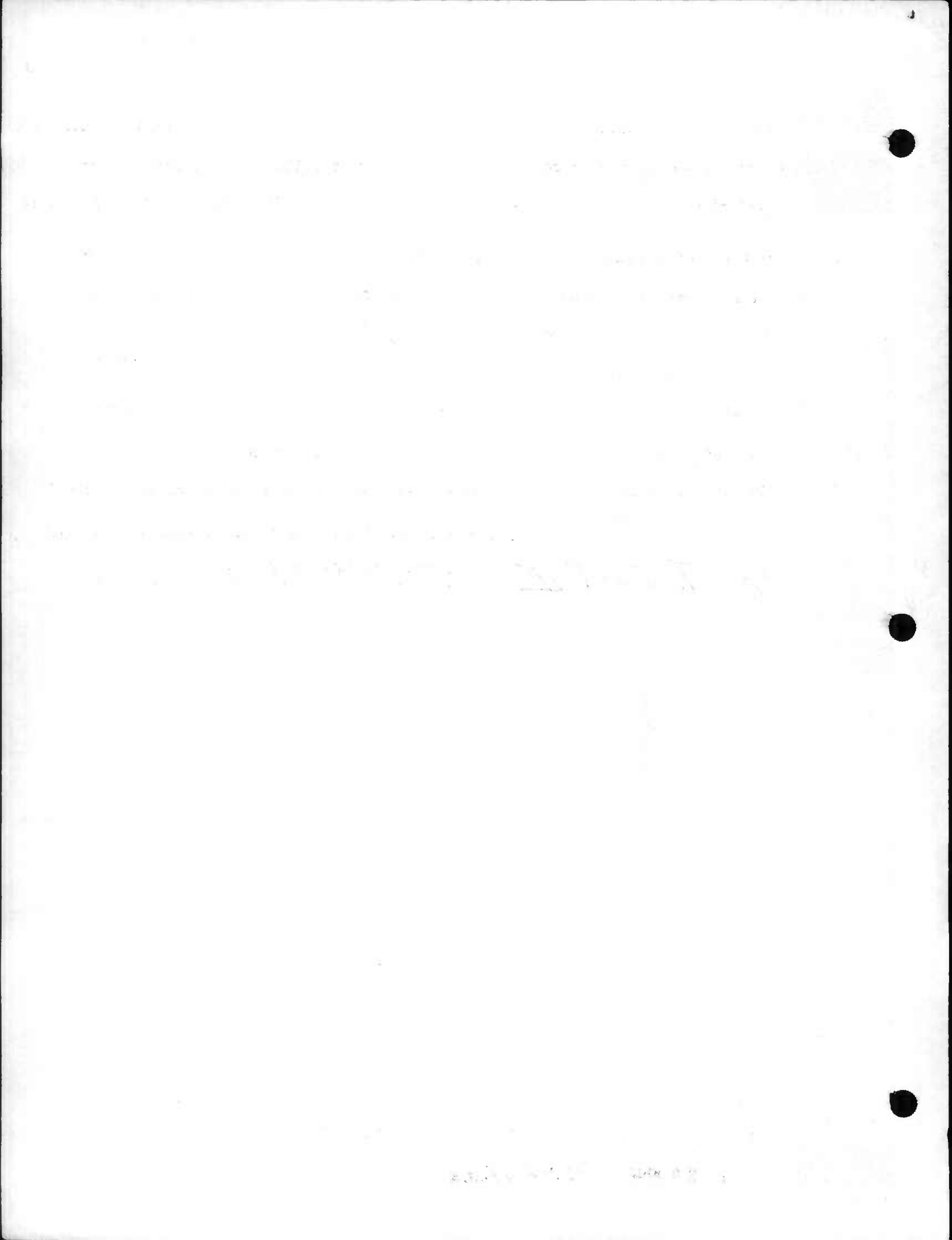
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 14999

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Beulah Mae Green   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 26, 1996   |   |  |  | 3. TIME OF DEATH<br>5:15 p m  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-22-6430   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br>May 2, 1912 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Center-- The Pines  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Easton  |   |  |  | 9c. COUNTY OF DEATH<br>Talbot   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |   |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Queen Annes   |  | 10c. CITY, TOWN OR LOCATION<br>Queenstown  |   |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>P.O. Box 255, Dudley Avenue  |  |  |  | 10f. ZIP CODE<br>21658   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA               |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4th<br>College (1-4 or 5+) _____  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Domestic   |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Cannery                        |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joshua Wilkins, Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Susie Harris  |   |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beverly Clark  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>29 Dunn Lane, Chester, Maryland 21619   |   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bryans U.M. Church Cem. 5/2/96                                |  |  | 20c. LOCATION — City or Town, State<br>Grasonville, Md. |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Phyllis A. Prince</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Md. 21601  |   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |   |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Urinary Infection</i>  |  |  |  |  |   |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |   |  |  |   |  |
| b. <i>Immobility</i>   |  |  |  |  |   |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |   |  |  |   |  |
| c. <i>Osteoarthritis</i>   |  |  |  |  |   |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |   |  |  |   |  |
| d. _____   |  |  |  |  |   |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pituitary tumor</i><br><i>Secondary hypothyroidism</i><br><i>Secondary Adrenal insufficiency</i>  |  |  |  |  |   |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M                           |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael Lees MD</i>  |  |  |  | 29c. LICENSE NUMBER<br>D42005  |   | 29d. DATE SIGNED (Month, Day, Year)<br>4/26/96     |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael Lees, MD., 2108 Red Apple Plaza, Chester, Md. 21619   |  |  |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAY 06 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Buckner Randall</i>   |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, II, 27,  
PER MEO FILM G-735 5/29/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 15000

|  |   |   |  |  |   |  |  |   |
|--|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARK LEE HALLER</b>                          |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MAY 4 1996</b>   |  | 3. Time of Death<br><b>21:37 PM</b>  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>5508 TALBOTT DRIVE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>NEW MARKET</b> |  | 4c. County of Death<br><b>FREDERICK</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-86-3980</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 27, 1960</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>New Market</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>5508 Talbot Dr.</b>   |   |   |  | 10f. Zip Code<br><b>21774</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>cook</b>   |   |  | 16b. Kind of Business/Industry<br><b>restaurant</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Claude B. Haller</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Holt</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia H. Haller/ mother</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12110 Main St. Libertytown, MD 21762</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairmount Cemetery</b>   |  | Data<br><b>5/7/96</b>  |   | 20c. Location - City or Town, State<br><b>Libertytown, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Catharine O. Hartzler</i>  |   |   |  | 22. Name and Address of Facility<br><b>Hartzler Funeral Home<br/>Libertytown, MD</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. DILATED CARDIOMYOPATHY</b><br>Dua to (or as a consequence of):<br><br><b>b. Dua to (or as a consequence of):</b><br><br><b>c. Dua to (or as a consequence of):</b><br><br><b>d. Dua to (or as a consequence of):</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MORBID OBESITY</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>Theodore McKinnon</i>   |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 5, 1996</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE McKinnon 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 9 1996</b>   |   | 32. Registrar's Signature<br><i>John A. Randall</i>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

